# Texas – NorthSTAR Waiver Program
## Proposal for a Section 1915(b) Capitated Waiver Program
## Waiver Renewal Submittal

**July 1, 2003**

**US DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**Center for Medicaid and State Operations**

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*PROPOSAL FOR A SECTION 1915(b) CAPITATED WAIVER PROGRAM*
**Waiver Renewal Submittal**

## Introduction

The waiver renewal submittal is for a State's use in requesting renewal of an existing Section 1915(b) waiver program involving Managed Care Organizations (MCOs), Health Insuring Organizations (HIOs), Prepaid Inpatient Health Plan (PIHPs), or Prepaid Ambulatory Health Plan (PAHPs) that provide contracted services to Medicaid enrollees under their care.

The use of this waiver renewal submittal is voluntary. The purpose is to facilitate the waiver renewal process and, thus, minimize unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request the renewal of an existing waiver and CMS's effort to process the renewal request.

All waiver renewal requests under section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on enrollee access to and quality of services, and its projected impact on the Medicaid program (42 CFR 431.55(b)(2)). This model section 1915(b) waiver renewal submittal will help States provide sufficient documentation in conjunction with a previously completed waiver application submittal for CMS to be able to determine whether the statutory and regulatory requirements of section 1915(b) of the Act have been satisfied.

Please note the following qualifications: (1) This version of the capitated waiver renewal submittal includes new requirements in the Medicaid Balanced Budget Act (BBA) regulation for managed care published June 14, 2002. States have until August 13, 2003 to comply with these requirements. States that want to submit a renewal request prior to August 13, 2003 that complies with pre-BBA requirements should use the September 23, 1999 version of the preprint. (2) States must still have MCO contracts and capitation rates prior approved by their CMS Regional Office (RO). PIHP/PAHP contracts and capitation rates must also be reviewed and approved by the CMS RO.

CMS staff will be glad to meet with the State, set up a conference call, or assist the State in any way in the completion of the application. States requesting the renewal of a waiver under only Sections 1915(b)(2), 1915(b)(3), or 1915(b)(4), or a combined 1915(b) and 1915(c), waiver should work with their CMS Regional Office to identify required submission items from this format.

## Instructions

This waiver renewal submittal builds upon the September 23, 1999 format for a waiver renewal request. It is essentially the same document but includes the new BBA requirements as well as some editorial changes.

Each section starts with one or more items under the heading "Previous Waiver Monitoring." The first question in "Previous Waiver Monitoring" asks for the results of monitoring various aspects of the waiver program over the previous 2-year waiver period. Please provide a summary of the State's monitoring results, including any breakdown available by sub-populations (i.e., if you have different or additional monitoring for foster care or SSI children than TANF, please indicate). Additional questions may be asked as appropriate.

Following "Previous Waiver Monitoring" is the subsection called "Upcoming Waiver Period." Its purpose is to give the State the opportunity to describe the waiver program for the next two years.

Please fill out the form in its entirety.

**Waiver Submittal Instructions (See State Medicaid Manual 2106)**

Please submit an original and four (4) copies of the waiver request to the appropriate office:

For MCO, PCCM and PAHP programs for dental or transportation services:

CMS, Center for Medicaid and State Operations, FCHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

For PIHP/PAHP programs focusing on Behavioral Health or Elderly and Disabled populations:

CMS, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

At the same time, send at least one copy of the waiver request to the appropriate CMS Regional Office. A waiver request submitted under 1915(b) of the Act must be approved, disapproved, or additional information requested within 90 days of receipt, or else the request is deemed granted. The Secretary approves or denies such requests in writing or informs you in writing with respect to any additional information that is needed in order to make a final determination with respect to the request. When additional information is requested, the waiver request must be approved or disapproved within 90 days of CMS receipt of the State's complete response to the request for additional information, or the

waiver request is granted.

The 90-day time period begins (i.e., day number one) on the day after the day the waiver is received by the addressee (i.e., the Secretary, the CMS Central Office (CO), or Regional Office (RO) designee) and ends 90 calendar days later. By 90 days, CMS must either approve the request, disapprove the request, or request additional information.

**General instructions**
States should check all items that apply, and provide additional information when specified. Leaving an item un-checked signifies it is not in the State's waiver program. Please note the following:

- A number of the items are required by federal statute, regulation, or policy. These required items are identified as such either in the instructions or headings for a section, or on an item by item basis. State must check-off these required items to affirm the State's intent to comply. If a required item is not checked, States should explain why it is not.

- All items are applicable to MCOs, PIHPs, and PAHPs unless otherwise noted.

- When sections require explanations, please insert the explanations into the document itself instead of attaching the explanation as an appendix, if possible.

- Because this is an application for a renewal of an existing waiver, CMS is requesting data or summary results from efforts the State has made during the previous waiver period to ensure compliance, quality of services, enrollee protections, etc. In an effort to ensure a complete submission package and to minimize the amount of additional information requested by CMS, please be sure to respond to these items as fully as possible so that additional information requests are not necessary.

- If a State modifies the wording of the waiver renewal submittal, please italicize and/or strikeout the modification. States may use italics, underlines, and strikeouts for any State-added information or modification to the standard waiver renewal submittal.

- Please update the table of contents prior to submitting the waiver to CMS to reflect the current page numbers and appendices.

- Please enclose any attachment directly following the section referenced and number the attachments with the section and question number, (e.g., Attachment C.I.a (Upcoming Waiver Period) is the attachment for question a. under point I. Elements of State Quality Strategies (Upcoming Waiver Period) in Section C.)

**Amendments or modifications during the renewal period**
During the renewal period, a State may wish to modify their Section 1915(b) waiver

program if an aspect of the program changes. Four (4) copies of the modification request must be submitted to the appropriate CO address listed above. A copy should also be sent to the RO at the same time.

CMS considers only waiver requests submitted by or through the Governor, State cabinet members responsible for State Medicaid Agency activities, the Director of the State Medicaid Agency, or someone with the authority to submit waiver requests on behalf of the Director.

CMS reviews the request and makes its recommendation to approve or disapprove the request based on the validity of the request and the documentation that is submitted to support the modification. Approvals of modification requests are effective from the date of approval through the end of the renewal period.

CMS receives a variety of waiver modification requests, which range from being minor in nature to extensive. Regardless of the extent of the needed modification, a State must submit an official request for modification to CMS as soon as it is aware of the need for a change in its program. The request must be submitted and approved prior to implementation of a change in the waiver program.

**Section A. GENERAL INFORMATION**

The **State** of **Texas** requests a waiver under the authority of Section 1915(b)(1) of the Act. The waiver program will be operated directly by the Medicaid agency **with oversight and management being provided by the Texas Department of Mental Health and Mental Retardation (TDMHMR).**

**Effective Dates:** This waiver renewal is requested for a period of 2 years; effective **November 6, 2003** and ending **November 5, 2005**.

**The waiver program is called NorthSTAR**.

**State Contact:** The State contact person for this waiver is **Dena Stoner** and can be reached by telephone at **(512) 424-6521**, or fax at **(512) 424-6665**, or e-mail at **dena.stoner@hhsc.state.tx.us.**

## I. Statutory Authority

**a. Section 1915(b)(1):** The State's waiver program is authorized under Section 1915(b)(1) of the Act, which provides for a capitated managed care program under which the State restricts the entity from or through which a enrollee can obtain medical care.

**b. Other Statutory Authority:** The State is also relying upon authority provided in the following section(s) of the Act:

1. _X_ **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among competing health plans in order to provide enrollees with more information about the range of health care options open to them. See Waiver Preprint Section A.IV.b Enrollment/Disenrollment and Section 2105 of the State Medicaid Manual. This section must be checked if the State has an independent enrollment broker.

2. __ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. Please refer to Section 2105 of the State Medicaid Manual. The savings must be expended for the benefit of the enrolled Medicaid beneficiary.

   Please list in Section A.IV .d.1 and Appendix D.III additional services to be provided under the waiver, which are not covered under the State plan. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval.

3._X_ **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. Please refer to Section 2105 of the State Medicaid Manual.

**c. Sections Waived.** Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

1. _X__**Section 1902(a)(1)** - Statewideness--This Section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

2. _X_**Section 1902(a)(10)(B)** - Comparability of Services--This Section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid enrollees not enrolled in the waiver program.

3. _X_**Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals enrolled in this program receive certain services through an MCO, PIHP or PAHP.

4._X__**Section 1902(a)(4)** – To permit the State to mandate beneficiaries into a single PIHP or PAHP.

5.___ **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request. As noted above, States requesting a combined 1915(b) and 1915(c) waiver should work with their CMS Regional Office to identify required submission items from this format.

## II. Background

[Required] Please provide a brief executive summary of the State's 1915(b) waiver program's activities since implementation, including experiences during the previous waiver period(s) and a summary of any program changes either planned or anticipated during the requested renewal period. Please specify the types of stakeholders or other advisory committee meetings that have occurred in the previous waiver period or are expected to occur under the future waiver

period. Please include descriptions of any advisory boards that have consumer representation. In addition, please describe any program changes and/or improvements that have occurred as a result of stakeholder involvement during the previous waiver period(s). Please describe any stakeholder involvement in monitoring of the previous waiver period. Finally, to the extent the State enrolls persons with special health care needs, please describe how the various stakeholders have been involved in the development, implementation, and ongoing operation of the program.

**RESPONSE:**

**Milestones**

**During the initial waiver approval period, the State of Texas issued a Request for Application (RFA) for the competitive selection of two Behavioral Health Organizations (BHOs) to provide managed behavioral healthcare services to NorthSTAR recipients. Five responses to the RFA were received and Magellan Behavioral Health and Value Options were selected to provide managed care services for NorthSTAR recipients. On June 30, 1999, CMS provided authorization for federal financial participation to operate NorthSTAR as a voluntary managed care program for a period of one year (or until such time as the waiver was approved for mandatory enrollment). In July of 1999, Magellan and ValueOptions began delivering services to NorthSTAR enrollees. The vast majority of these early enrollees were not Medicaid eligible however a small number were voluntary Medicaid enrollees.**

**On September 7, 1999, the State of Texas received initial approval from the Center for Medicaid and State Operations (CMS) for the implementation of NorthSTAR as a mandatory program under a 1915(b) waiver. On October 14, 1999, CMS granted a request by the State to delay the implementation date of the waiver until November 1, 1999. After receiving CMS's initial authorization for implementation, the State's enrollment broker Maximus, Inc., began the distribution of educational materials printed in both English and Spanish to all Medicaid recipients residing in the NorthSTAR service area. Maximus also began a coordinated series of community educational events**
**and enrollment outreach activities designed to raise community awareness and to answer questions from eligible individuals and the public concerning NorthSTAR.**

**To assure that consumers and the local community were given a voice in the implementation and ongoing oversight of NorthSTAR, the State created an independent Local Behavioral Health Authority (LBHA) which came to be known as the Dallas Area NorthSTAR Authority (DANSA). DANSA provides ombudsman services to NorthSTAR enrollees, provides staff to serve on the Quality Improvement Committee of the contracted Behavioral Health Organizations (BHO), and serves as a conduit to relay issues of community concern and complaints directly to the State. DANSA staff also meets regularly with various community based organizations, consumer and advocacy groups, managed care coordination groups as well as NorthSTAR service providers. DANSA began providing services to NorthSTAR enrollees in July of 1999.**

**In February of 2000, the State sought an amendment to the waiver to expedite the enrollment of pregnant women into the NorthSTAR program. This amendment was approved by CMS on April 5, 2000. In May of 2000, the State sought a second amendment to the waiver to adjust the UPL calculations to delete recipient months associated with populations that were not covered under the waiver. This amendment request was approved by CMS on June 28, 2000.**

**The State provided notification to CMS in mid-June of 2000, that Magellan Behavioral Health was likely to decline the renewal of the NorthSTAR contract for a second year. On June 30, 2000, the Texas Department of Mental Health and Mental Retardation (TDMHMR) received official notification from Magellan that they would not be renewing the contract for a second year. Magellan did agree to continue to provide services to enrollees during a sixty-day transition period. The State sought a third amendment to the waiver to allow NorthSTAR to operate with a single BHO until such time as a replacement for Magellan could be obtained. At that time the State believed that a replacement for Magellan could be obtained and attain full operational status on or before November 1, 2001. ValueOptions began providing services to all NorthSTAR recipients on October 1, 2000.**

**In accordance with the timetable provided to CMS, the State issued an RFA for the competitive selection of a BHO to replace Magellan. In response to the RFA the State received three preliminary (non-binding) letters of intent - but no formal applications were received. On February 15, 2001, the state provided verbal notification to CMS that no bidders had responded to the RFA. The State believes that the financial incentives may be inadequate to attract multiple BHOs to provide services under NorthSTAR. The State was granted permission by CMS to operate with a single contracted BHO with the approval of the waiver submission beginning November 1, 2001 and ending October 31, 2003. With this submission the State again requests CMS permission to operate with a single contracted BHO for the duration of the waiver period beginning November 6, 2003 ending November 5, 2005.**

**On April 7, 2001 and again on October 3, 2002, NorthSTAR was named as a semifinalist in the Innovations in American Government Awards Program, an awards program of the Institute for Government Innovation at the John F. Kennedy School of Government at Harvard University. This awards program is administered in partnership with the Council for Excellence in Government.**

**Consumer and Advocate Involvement**

**NorthSTAR has been generally well received by consumers and advocates throughout the service area. Various organizations including the local chapters of the National Alliance for the Mentally Ill (NAMI) serving the NorthSTAR area and the Mental Health Association of Greater Dallas have been vocal supporters of NorthSTAR. Several specific benefits that are unique to NorthSTAR have been cited by consumers**

**and advocates. These benefits include:**

1. **A choice of providers**
2. **Choice of the most appropriate treatment and services**
3. **Continuity of care (for people who gain or lose Medicaid eligibility)**
4. **Improved access to services**
5. **Local oversight with ombudsman services available (provided through the Local Behavioral Health Authority)**
6. **Positive outcomes resulting from a total separation of authority and provider entities (i.e., the entity responsible for authorization is not the provider of services)**
7. **A sense of inclusion which has arisen from providing formal channels for both consumer and advocate input in the early planning and implementation phases of the program.**
8. **The elimination of waiting lists (for non-Medicaid consumers)**

**The results of an adult consumer satisfaction survey conducted by TDMHMR indicates that overall NorthSTAR adult consumers are satisfied with the services they receive. A composite rating of general satisfaction domain indicates that 87.4% of NorthSTAR consumers are satisfied with the services they have received (Refer to Table A.1 below).**

**NorthSTAR incorporates specific features to help ensure consumer involvement including:**

**<u>Adult Satisfaction Survey</u>**

**The Texas Adult Mental Health Consumer Survey is a modification of the Mental Health Statistical Improvement (MHSIP) consumer survey of mental health provider systems. These modifications were a result of direct input by psychologists, research specialists, consumers and advocates. There are two remaining negatively worded items that are generally not used in the analysis of the data.**

**The Texas Adult Consumer Satisfaction Survey was distributed to a random sample of NorthSTAR adult enrollees, which included both Medicaid and non-Medicaid enrollees. Sampling is done to achieve an 80% +/- 7% confidence in reliability of results.**

**Summary results of this survey are presented in Table A.1. below.**

| DOMAIN | DOMAIN COMPOSITE SATISFACTION RATING |
|---|---|
| ACCESS | 84.3% |
| OUTCOMES | 69.4% |
| SATISFACTION | 87.4% |
| QUALITY/APPROPRIATENESS | 84.9% |

**Table A.1. – NorthSTAR Adult Consumer Satisfaction Survey – All Populations -FY 02**

The responses of Medicaid eligible responders were extracted from the total

responses and analyzed separately. The results from this analysis are presented in Table A.2.

**Domain Comparisons (Medicaid Adult Enrollees Only):**

| DOMAIN | YEAR | AGREE | NEUTRAL | DISAGREE |
|---|---|---|---|---|
| ACCESS | 2002 | 82.1% | 7.3% | 10.62% |
| OUTCOMES | 2002 | 64.3% | 20.8% | 14.9% |
| QUALITY | 2002 | 79.4% | 12.5% | 8.1% |
| SATISFACTION | 2002 | 88.0% | 4.3% | 7.6% |
| AVERAGE OF FOUR DOMAINS | 2002 | 78.5% | 11.2% | 10.3% |

**Table A.-2-NorthSTAR Medicaid Enrollee's Satisfaction SFY 2002**

**Child and Family Survey**

**The FY 2002 Child and Family Surveys were developed under the 16-State Performance Measures Study, a federal initiative funded by the Mental Health Statistics Improvement Project (MHSIP), a branch of the Center for Health Care Services (CHCS). There are two versions of the MHSIP child and family surveys: the Youth Services Survey (YSS) for children 13 years and older, and the Youth Services Survey for Families (YSS-F). Texas uses the results of the YSS-F for reporting to CMHS and the state legislature. Likewise, in this document, the emphasis is on the results of the YSS-F (also referred to as the "parent" or "family" surveys).**

**Questions were clustered into five domains, which included:**

- **Access**
- **Outcomes**
- **Satisfaction**
- **Participation in Treatment**
- **Cultural Sensitivity**

**Preliminary survey results across the - five domains for the children's survey are presented in Table A.3.**

| DOMAIN | AGREE | NEUTRAL | DISAGREE |
|---|---|---|---|
| ACCESS | 86.9% | 5.5% | 7.6% |
| OUTCOMES | 63.9% | 20.5% | 15.6% |
| SATISFACTION | 82.0% | 9.8% | 8.2% |
| PARTICIPATION | 87.1% | 6.7% | 6.3% |
| CULTURAL SENSITIVITY | 93.1% | 4.4% | 2.5% |

**Table A.3. – NorthSTAR Child and Family Survey - – All Populations - SFY 2002**

**The agreement rate for Outcomes was noticeably lowest of all the domains, which is in line with the national trend for both the Adult and Child/Family Surveys.**

**Consumer Involvement**

**NorthSTAR was designed with specific features to ensure that consumers, family members, advocates and concerned citizens have the ability to voice their concerns and suggestions regarding how the NorthSTAR program was designed and how the program operates on a day-to-day basis. To assure that consumers and the local community were given strong representation in the implementation of NorthSTAR, the State created an independent Local Behavioral Health Authority (LBHA) which provides the local community with a voice for expressing concerns and suggestions related to NorthSTAR. The LBHA works directly with consumers, families, providers and various local groups and organizations to gather input from the community. The LBHA then provides a monthly report to the State which details consumer and community contacts and identifies relevant issues related to the NorthSTAR program from a local perspective.**

**The NorthSTAR BHO also participates in numerous public meetings in order to better serve the needs of consumers and the local community.**

**From the time of initial implementation, multiple routine advisory meetings have been ongoing. The BHO, the LBHA (also know as the Dallas Area NorthSTAR Authority (DANSA) and the State routinely attend all advisory meetings.**

**Principle ongoing advisory meetings:**

- **Regional Advisory Committee (RAC) (consumers and stakeholders, i.e. providers, HMOs, interacting agencies) – during the first year of operations these meetings were generally held on a monthly basis and are now held at least quarterly.**
- **Statewide RAC (includes consumers, advocates, stakeholders) – generally held quarterly**
- **DANSA board meetings**
- **DANSA consumer advisory committee – generally held monthly**

**Other community stakeholder meetings:**

- **The BHO and DANSA attend the local Community Mental Health Center board meetings, the National Alliance for the Mentally Ill (NAMI) meetings, the Community Resource Coordination Group meetings, and meetings of the Dallas County Medical Society.**
- **The BHO attends a variety of community groups such as the MHA's child advisory committee, the APAA (Association of Person's Affected by**

**Addiction), the Consumer council for Mental Health Advocacy, Offenders with Mental Impairments meetings.**

**Additionally both DANSA and consumers are included in the BHO's Quality Improvement (QI) committees. This provides a direct opportunity for these groups to have regular, systematic involvement in the clinical operations of the plan. (All QI, Utilization Management (UM), provider issues, enrollee issues, complaints, and on-going evaluative studies are reviewed in these meetings).**

**Furthermore, State staff has met independently with numerous advocate, consumer and community organizations and groups, some of which include:**

- **NAMI Dallas**
- **NAMI Collin Co.**
- **Mental Health Association of Dallas**
- **Coalition on Mental Illness**
- **Dallas County Medical Society**
- **Special Need Offenders Workgroup**
- **Area Community Resource Coordination Groups (for children)**
- **Texas Medical Association**

**Complaints**

**While the State recognizes that complaint-based evaluations have certain limitations, when used properly this approach can serve as an early warning system for consumer or provider concerns. Throughout the second waiver period the State continued to develop, and refine the complaint system that allowed the State to flag potential individual and system problems.**

**From November of 2001 through February 2003 the monthly rate of complaints from providers and consumers (including both Medicaid and non-Medicaid enrollees) has remained very low.**

**Chart A.1 depicts the monthly total number of complaints from <u>all</u> sources (consumers, providers and others) from November 2001 through April 2003.**

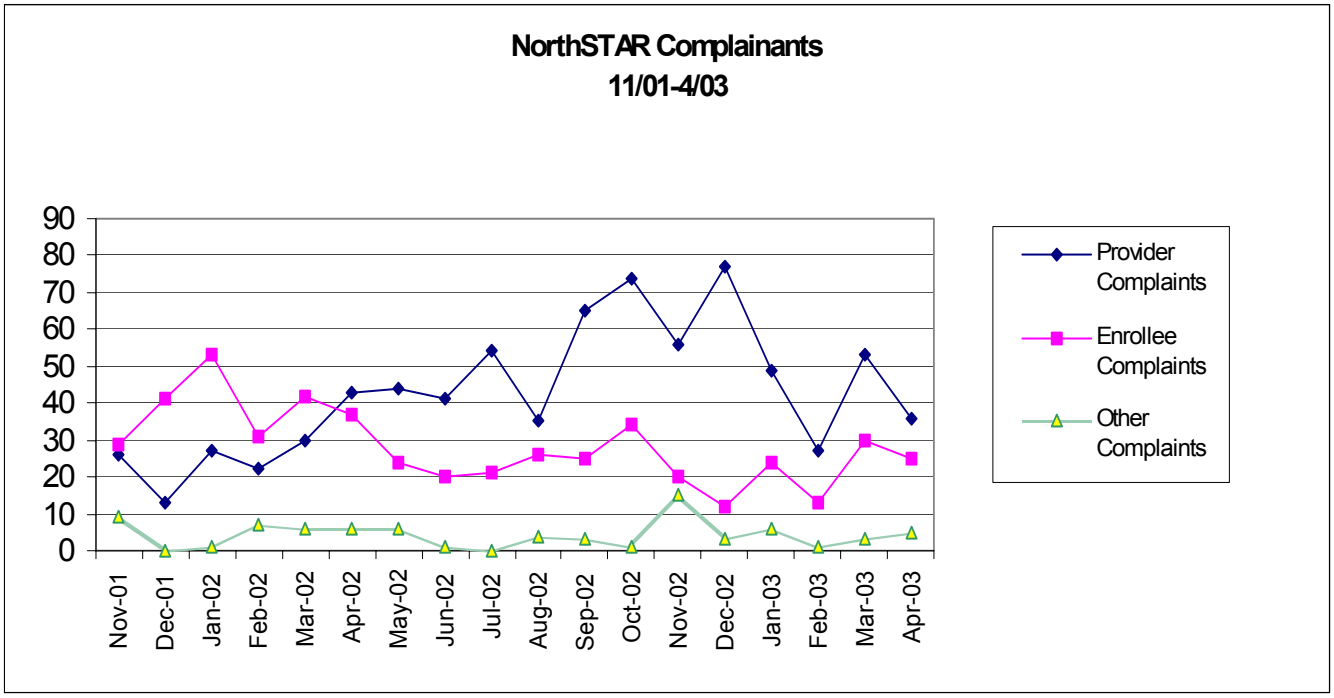



**Chart A.1. – Total NorthSTAR Complaints By Month – 11/01 – 4/03.**
**Note: Most provider complaints involve claims payment issues. While the number of provider complaints rise in 8/02 through 12/02, most of these came from a very small number of providers. Additionally, the total dollar amounts involved in these claim complaints has decreased over the last year.**

## III. General Description of the Waiver Program

**(a) Type of Delivery Systems:** The State will be entering into the following types of contracts with an MCO, PIHP, or PAHP. The definitions below are taken from federal statute. However, many "other risk" or "non-risk" programs will not fit neatly into these categories (e.g. a PIHP program for a mental health carve out is "other risk," but just checking the relevant items under "2" will not convey that information fully).

1. ___ **Risk-Comprehensive (fully-capitated—MCOs or HIOs):** Risk-comprehensive contracts are generally referred to as fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities. Check either (a) or (b), and within each the items that apply:

   (a)__ The contractor is at-risk for inpatient hospital services and any one of the following services:

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services, and
ix.___ Home Health services.

(b)__ The contractor is at-risk for three or more of the above services ((i) through (ix)). Please mark the services in (a).

2. _X_ **Partial Risk (PIHP/PAHP):** Other risk contracts are those that have a scope of risk that is less than comprehensive. The contractors in these programs are either PIHPs or PAHPs (e.g., a PIHP for mental health/substance abuse). References in this preprint to PIHPs/PAHPs generally apply to these other risk entities. For PIHPs, please check either (a) or (b); if (b) is chosen, please check the services that apply. For PAHPs, please check (b), and indicate the services that apply.

(a)_X_ The contractor is a PIHP at-risk for all inpatient hospital services,

or

(b)__ The contractor is a PIHP or PAHP at-risk for two or fewer of the below services ((i) through (x)).

i.___ Outpatient hospital services,
ii.___ Rural health clinic (RHC) services,
iii.___ Federally qualified health clinic (FQHC) services,
iv.___ Other laboratory and X-ray services,
v.___ Skilled nursing facility (NF) services,
vi.___ Early periodic screening, diagnosis and treatment (EPSDT) services,
vii.__ Family planning services,
viii.__ Physician services
ix.___ Home Health services.
x.____ Other:
___dental
___transportation
___a subset of inpatient hospital services (e.g. only mental health admissions)

**NorthSTAR is a behavioral health "carve-out" The BHO is at full**

**risk (fully capitated) for providing the full range of Medicaid behavioral health services covered under the Medicaid State Plan.**

3. ___ **Non-risk:** Non-risk contracts involve settlements based on fee-for-service (FFS) costs (e.g., a PIHP contract where the State performs a cost-settlement process at the end of the year). Please provide a brief narrative description of non-risk model, which will be implemented by the State.

4. ___ Other (Please provide a brief narrative description of the model. If the model is an HIO, please modify the entire preprint accordingly):

**a. Geographical Areas of the Waiver Program:** Please indicate the area of the State where the waiver program will be implemented. (Note: If the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification request must be submitted to CMS):

1. ____ Statewide -- all counties, zip codes, or regions of the State have managed care (Please list in the table below) or

2. __X__ Other (please list in the table below):

Regardless of whether item 1 or 2 is checked above, in the chart below please list the areas (i.e., cities, counties, and/or regions) and the name and type of entity (MCO, PIHP, PAHP, HIO, or other entity) with which the State will contract:

| City/County/Region | Name of Entity* | Type of Entity (MCO, PIHP, PAHP, HIO, or other entity) |
|---|---|---|
| Medicaid SDA 6 | ValueOptions | **MCO (BHO), PIHP** |
| | | |
| | | |

*The State should list the actual names of the contracting entities. Cost-effectiveness data should be submitted for every city/county/region listed here as described in Section D.

**b. Requirement for Choice:** Section 1932(a)(3) of the Act and 42 CFR 438.52 require the State to permit individuals to choose from not less than two managed care entities.

1. ___ This model has a choice of managed care entities.
   (a)__ At least one MCO and PCCM (please use the combined PCCM Capitated Waiver Renewal Preprint)
   (b)__ One PCCM system with a choice of two or more Primary Care Case Managers (please use the PCCM Waiver Renewal preprint)
   (c)__ Two or more MCOs
   (d)__ At least one PIHP or PAHP and a combination of the above entities

2. ___ This model is an HIO.

3. _X_ The State is opting to use the exception for rural area residents in Section 1932(a)(3) and 42 CFR 438.52(b). Please list the areas of the State in which the rural exception applies:

   **NorthSTAR is a fully capitated behavioral health carve-out that serves seven North Texas counties - only two of which may be considered to be urban counties. When NorthSTAR was initially implemented the State selected two competing Behavioral Health Organizations, Magellan Behavioral Health Inc. and ValueOptions to provide services to eligible individuals residing in the service area. After providing services to NorthSTAR enrollees for eleven months, Magellan notified the State that they were unwilling to renew the contract for a second year - citing financial reasons for their decision. When Magellan withdrew from NorthSTAR the State published a Request for Application (RFA) to procure a replacement BHO. The State received three non-binding letters of intent in response to the issuance of the RFA - but no applications were ever received.**

   **To help assure cost effectiveness, the State has established a Direct Services Claims Target (DSCT) which gives the BHO little allowance for administrative costs or profit. This approach requires the participating BHO to be efficient. ValueOptions was able to leverage their existing regional service center to find efficiencies while Magellan had to create a comprehensive operation from scratch.**

   **The State believes that adding a second administrative structure actually does little to enhance the quantity or availability of services within a small capitated behavioral health "carve out" program – although the addition of a second plan does increase administrative costs. NorthSTAR has worked to ensure BHO responsiveness in numerous ways, including the development and support of an independent Local Behavioral Health Authority to**

**provide ombudsman and advocacy services for NorthSTAR consumers and by creating a State level position that works directly with consumer complaints and issues which may arise. These two mechanisms add genuine value to the program for they represent a very effective and less costly method of ensuring that consumer issues are quickly and effectively addressed by the BHO.**

**When Magellan transitioned out of NorthSTAR, the State compared the composition of the provider networks of both BHOs. It was interesting to note that there were over 460 contracted provider in NorthSTAR - however there were only 7 group/facility providers in the Magellan network that were not already contracting with ValueOptions either as a group/facility or individually and although there were 70 individual providers in Magellan's network who had never contracted with ValueOptions, 59 of these had never filed a claim or requested an authorization for a service. Effectively the difference between the two networks consisted of roughly 18 active providers. This finding has caused the State to seriously question the cost effectiveness of having two competing organizations delivering an almost identical array of services to a small and relatively static population.**

**While consumers have spoken favorably of having a choice of plans, the majority of positive comments pertaining to choice have centered on the wide choice of providers. Since the departure of Magellan, the ValueOptions network has remained stable offering a equally wide choice of providers**

**Another significant area of concern in contracting with two plans involves the difficulties inherent in assuring that a new plan would have a sufficient number of enrollees to even have a slim chance of viability. Since consumer satisfaction measures are fairly high and the number of complaints limited, there is no compelling reason to believe that a large number of individuals would voluntarily elect to change plans. The only way to assure a chance of viability for a new plan would be to require a significant number of consumers currently enrolled with ValueOptions to change plans. This disruption in continuity of care and the resulting consumer confusion does not seem justifiable in light of the limited gains to be achieved from the deployment of a two plan model.**

**In response to the above, the State was granted permission by CMS to operate with a single contracted BHO with the approval of the waiver submission beginning November 1, 2001 and ending October 31, 2003. Additionally, the State further requests CMS permission to operate with**

**a single contracted BHO for the duration of the waiver period beginning November 6, 2003 ending November 5, 2005.**

4.___ The State is requesting a waiver of 1902(a)(4) to permit the State to mandate beneficiaries into a single PIHP/PAHP.

**c. Waiver Population Included:** The waiver program includes the following targeted groups of beneficiaries. Check all items that apply:

1._X_ Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)

2._X_ Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)

3._X_ Blind/Disabled Children and Related Populations (SSI)

4._X_ Blind/Disabled Adults and Related Populations (SSI)

5._X__Aged and Related Populations (Please specify: SSI, QMB, Medicare, etc.)
**Under NorthSTAR the State will provide services to individuals who are SSI eligible and to MQMBs but will <u>not</u> provide services to QMBs.**

6.___ Foster Care Children
**Although, State Foster Care children are not specifically covered in this waiver, these children will be covered for a transition period from the waiver to traditional Fee For Service Medicaid (FFS). Children receiving services under the waiver, who are removed from the home by Child Protective Services and placed into foster care, will transition from NorthSTAR to FFS at the beginning of the month following the month of their removal or at the first possible month due to state Medicaid systems close schedule. Services are provided for a transition period only and not on-going while the child remains in foster care.**

7.___ Title XXI SCHIP - includes an optional group of targeted low income children who are eligible to participate in Medicaid if the State has elected the State Children's Health Insurance Program through Medicaid

8.___ Other Eligibility Category(ies)/Population(s) Included - If checked, please describe these populations below.

9._X_ Other Special Needs Populations. Please ensure that any special populations in the waiver outside of the eligibility categories above are listed here (Please explain further in Section F. Special Populations)
   i. _X_ Children with special needs due to physical and/ or mental illnesses,
   ii. _X_ Older adults,
   iii. _X_Foster care children,
   iv. _X__Homeless individuals,
   v. _X_ Individuals with serious and persistent mental illness and/or substance abuse,
   vi. _X__Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
   vii. __ Other (please list):

**d. Excluded Populations:** The following enrollees will be excluded from participation in the waiver:

1. ___ Have Medicare coverage, except for purposes of Medicaid-only services;

2. ___ Have medical insurance other than Medicaid;

3. _X_ are residing in a nursing facility;

4. _X_ are residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

5. ___ are enrolled in another Medicaid managed care program;

6. ___ have an eligibility period that is less than 3 months;

7. ___ are in a poverty level eligibility category for pregnant women;

8. ___ are American Indian or Alaskan Native;

9. ___ participate in a home and community-based waiver;

10. _X_ receive services through the State's Title XXI CHIP program;

11.__ have an eligibility period that is only retroactive;

12. _X_ are included under the State's definition of Special Needs Populations. Please ensure that any special populations excluded from the waiver in the eligibility categories in I. above are listed here (Please explain further in Section F. Special Populations if

necessary);

i. ___ Children with special needs due to physical and/ or mental illnesses,
ii. ___ Older adults,
iii. _X_Foster care children,
iv. ___Homeless individuals,
v. ___ Individuals with serious and persistent mental illness and/or substance abuse,
vi. ___Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or
vii. __ Other (please list):

13. _X_have other qualifications which the State may exclude enrollees from participating under the waiver program. Please explain those reasons below:
**Individual's receiving services through the State's IMD over age 65 program.**

**e. Automated Data Processing:** Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.
**The State is currently in compliance and will remain in compliance with these guidelines.**

**f. Independent Assessment:** The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on enrollee access to care of adequate quality. The Independent Assessment is required for at least the first two waiver periods. **This assessment is to be submitted to CMS at least 3 months prior to the end of the waiver period.** [Please refer to SMM 2111 and CMS's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1. _X_ This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to CMS as required.
**An independent Assessment is in the process of being completed and will be forth coming.**

2. __ Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State

that an Independent Assessment is needed in the waiver approval letter.

## IV. Program Impact

In the following informational sections, please complete the required information to describe your program.

**a.** **Marketing** including indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general) and direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). *Information to potential enrollees and enrollees (i.e., member handbooks), is addressed in Section H.*

**Previous Waiver Period**

1. _X_ [Required for all elements checked in the previous waiver submittal] Please describe how often and through what means the State monitored compliance with its marketing requirements, as well as results of the monitoring. [Reference: items A.III.a.1-7 of 1999 initial preprint; as applicable in 1995 preprint, or items A.III.a Upcoming Waiver Period of 1999 Waiver Renewal preprint].

**The contract between the State and the NorthSTAR BHO outlines marketing guidelines that the BHO must follow. All marketing materials and activities must be prior approved by the State, thereby ensuring that enrollees receive accurate, unbiased information about their plan and provider choices. This is monitored through the prior approval process and through review of complaints received by the State. NorthSTAR employs the services of an independent enrollment broker MAXIMUS, Inc. MAXIMUS has the responsibility for mailing consumer enrollment and educational materials to eligible individuals and for conducting consumer education and enrollment events. The contracted BHO is required to submit all informational and marketing materials to the State for approval prior to distributing those materials to the public. The State has reviewed and approved all informational, marketing and enrollment materials submitted by the contracted BHO prior to public distribution.**

**All direct mailings to enrollees/eligible individuals whether of a marketing or informational nature have been pre-approved by the State prior to mailing.**

**The State tracks complaints related to marketing practices. During the last waiver period the State did not receive any complaints related to BHO marketing practices/materials. The State did receive a total of two**

**complaints related to network provider marketing-related issues. The complaints were resolved with the provider to the complainant's satisfaction.**

**Upcoming Waiver Period** Please describe the waiver program for the upcoming two-year period.

1.___ The State does not permit direct or indirect MCO//PIHP/PAHP marketing (go to item "b. Enrollment/Disenrollment")

2._X_ The State permits indirect MCO/PIHP/PAHP marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP in general). Please list types of indirect marketing permitted.
**The State permits the BHO to conduct indirect marketing for the BHO in general. However, all marketing materials regarding the program or Medicaid in general, including advertising scripts, are prior approved by the State. The BHO is prohibited from targeting specific types of clients with such marketing, and the BHO must follow all marketing guidelines set by the State regardless of the marketing medium. No marketing may be conducted without prior approval by the State. The BHO may use any State-approved marketing strategy, which may include, but is not limited to, health seminars, health fairs, community outreach programs, multimedia advertisements, mailers, and billboard advertisements.**

3.___ The State permits direct MCO/PIHP/PAHP marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Please describe the State's procedures regarding direct and indirect marketing by answering the following questions and/or referencing contract provisions or Requests for Proposals, if applicable.

4._X_ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation/prohibition and how the State monitors this:
**Under the NorthSTAR contract, the BHO may offer nominal gifts valued at no more than $10 and free health screenings approved by the State to potentially eligible individuals as long as these gifts and free health screenings are offered whether or not the individual enrolls in the Contractor's plan. Free health screenings must not be used to discourage less healthy individuals from enrolling in the BHO's plan. Distribution of such gifts must be prior-approved by the State. The State tracks complaints related to BHO marketing practices.**

5._X_ The State permits MCOs/PIHP/PAHPs to pay their marketing representatives based on the number of new Medicaid enrollees

he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
**The State has stipulated in the contract that the BHO may not use marketing agents who are paid solely by commission. Beyond this restriction, the State does not dictate how the BHO- pays their marketing representatives.**

**An Enrollment Broker employee, and not the BHO marketing representative, enrolls clients who opt to enroll at enrollment events. Because clients may choose to mail or phone in their enrollment later, it would be difficult for the BHO to isolate which clients may have joined their plan due to the efforts of a particular marketing representative. The State prohibits coercive or fraudulent marketing practices. The State pre-approves all marketing materials, and reviews all complaints. Violations are investigated with appropriate action taken against the party involved.**

**The State has incorporated specific requirements into the contracts which prohibit BHO from using marketing agents who are paid solely by commission. Furthermore, the State contract contains specific provisions, which govern the marketing practices of BHO and their marketing representatives including specific provisions that prohibit them from:**

**(a) engaging in marketing or enrollment practices that discriminate because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual orientation, physical or mental handicap, health status, or requirements for health care services;**
**(b) engaging in door-to-door marketing, telephonic, or other "cold-call" marketing;**
(c) **conducting face-to-face marketing at public assistance offices;**
(d) **making any material misrepresentations to any person regarding the NorthSTAR program, Medicaid, Medical Assistance, or Title XIX;**
**(e) offering individuals any material or financial gain as an inducement to enroll except for nominal gifts valued at $10.00 or less. (distribution of such gifts must be prior-approved by the State);**
**(f) seeking to influence an individual's enrollment by linking the BHO's managed care products with the sale of other insurance products.**

**The State monitors compliance with these contractual**

**requirements by tracking all complaints related to BHO marketing practices. Furthermore, DANSA monitors the BHO and facilitates BHO interaction with Community Based Organizations (CBOs), providers, advocates, and consumers.**

**The State is seeking additional CMS authorization to operate NorthSTAR with a single BHO. If the State is given authorization to continue to operate with a single plan, the focus of distributed materials will be less oriented to marketing and more toward consumer education.**

6._X_ The State requires MCO/PIHP/PAHP marketing materials to be translated into the languages listed below (If the State does not translate enrollee materials, please explain):
**The BHO is required to ensure that all marketing and enrollment materials are available in the language of any population group that comprises more than 10% of the covered lives. Currently the only languages comprising 10% of the covered lives are English and Spanish. The BHO must ensure that all written plan materials required to be translated are certified by a professional translator or translation service**

The State has chosen these languages because (check those that apply):

i. __ The languages comprise all prevalent languages in the MCO/PIHP/PAHP service area.
ii._X_ The languages comprise all languages in the MCO/PIHP/PAHP service area spoken by approximately _10_ percent or more of the population.
iii.__ Other (please explain):

7._X_ The State requires MCO/PIHP/PAHP marketing materials to be translated into alternative formats for those with visual impairments.

8. **Required Marketing Elements**: Listed below is a description of requirements that the State must meet under the waiver program (items a through g). If an item is not checked, please explain why.

The State:

(a)_X_Ensures that all marketing materials are prior approved by the State

(b)_X_Ensures that marketing materials do not contain false or

misleading information

(c)_X_Consults with the Medical Care Advisory Committee (or subcommittee) in the review of marketing materials

(d)_X_Ensures that the MCO/PIHP/PAHP distributes marketing materials to its entire service area

(e)_X_Ensures that the MCO/PIHP/PAHP does not offer the sale of any other type of insurance product as an enticement to enrollment.

(f)_X_ Ensures that the MCO/PIHP/PAHP does not conduct directly or indirectly, door-to-door, telephonic, or other forms of "cold-call" marketing.

(g)_X_Ensures that the MCO/PIHP/PAHP does not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of health services.

**b. Enrollment/Disenrollment:**

**Previous Waiver Period**

1. [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with Enrollment/Disenrollment requirements. Please include the results from those monitoring efforts for the previous waiver period. (Reference items A.III.b of the 1999 initial preprint; items A.8, 9, 17(g-j), 20, and 22 of 1995 preprint; items A.III.b Upcoming Waiver Period of 9/23/99 Waiver Renewal).

**Texas uses an independent enrollment broker to enroll Medicaid eligible individuals. An independent enrollment broker was selected in order to eliminate potential conflicts of interest in the enrollment/disenrollment process. Additionally, to ensure that involuntary disenrollments are properly handled, the State has implemented a policy that does not allow the involuntary disenrollment of any individual without direct State authorization. These two steps have eliminated most of the potential problems associated with the enrollment/disenrollment process. The State also tracks all complaints from any source related to the enrollment process. During the last waiver period the State received no complaints related to the Enrollment Broker. Twelve (12) complaints were received from Medicaid eligible individuals related to the enrollment process. Seven of these complaints were related to mandatory enrolled Medicaid recipients wanting to disenroll, and five were related**

**to ineligible Medicaid types wanting to enroll, county of residence issues, and providers trying to inappropriately financially assess Medicaid eligibles. In the cases of Medicaid enrollees wanting to disenroll, these issues were resolved by State staff educating the enrollee about the benefits of NorthSTAR, the BHO working with the enrollee on finding a suitable network provider, or the BHO establishing a single case agreement that allowed the enrollee to continue seeing their existing provider. The cases of incorrect county of residence on Medicaid/Social Security records were resolved by correcting these records. In the cases of providers trying to financially assess Medicaid eligibles, the State staff intervened and provided education to the providers involved.**

**Upcoming Waiver Period** - Please describe the State's enrollment process for MCOs/PIHPs/PAHPs by checking the applicable items below.

1. _X_ **Outreach:** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program (e.g., media campaigns, subcontracting with community-based organizations or out stationed eligibility workers). Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

   **The State's Enrollment Broker, MAXIMUS, Inc. performs outreach activities, conducts enrollment events, and assists clients with enrollment in person and over the phone. Outreach includes notifying clients about the program through publicized events, partnering with community based organizations to disseminate information about the program, and brochures, flyers and posters in the clients' communities. A newly eligible individual receives an enrollment kit in the mail from MAXIMUS. The enrollment kit contains information about NorthSTAR, including their provider network and instructions for enrolling via mail, over the phone, or at an enrollment event.**

   **If the eligible individual has questions or needs assistance, he or she can contact MAXIMUS. If necessary, MAXIMUS staff does home visits to help eligible individuals to understand their choices and the enrollment process. Eligible individuals are counseled through a plan information sheet included in enrollment mail-outs; audio and video presentations given in Texas Department of Human Services (TDHS) eligibility offices; by outreach staff located in the community; and by phone. The Enrollment Broker makes peer counseling and one-on-one counseling available to clients. In addition to the training MAXIMUS staff received on the traditional Medicaid population, training on the NorthSTAR population and their special needs is required by the state. The MAXIMUS contacts with community based organizations and consumer advocacy organizations provide a critical link between the enrollment**

**broker and the NorthSTAR population.**

**NorthSTAR also provides for specific outreach to homeless individuals who may be in need of behavioral health services through a specialty homeless outreach program operated through Dallas MetroCare. The State has been providing quarterly reports to CMS on the number of homeless individuals identified and enrolled for services.**

**MAXIMUS performs outreach activities throughout the service area with numerous community agencies, organizations and events. A partial list of such outreach activities during the months of December, 2002-February 28, 2003 includes:**

- **Dallas DHS Ledbetter**
- **Garland-Garland Health Center**
- **Arlington-C.N.A.**
- **Ennis-Ennis Early Childhood Center**
- **Garland – Vietnamese Community Festival**
- **Dallas – YWCA**
- **Waxahachie – Womens' Resource Center**
- **Dallas -Kwanzaa Fest**
- **Numerous Local Department of Human Services Offices**
- **Dallas - Stewart Creek Elementary**
- **Rockwall-Community Resource Coordination Group**
- **Dallas – -Stewart Creek Elementary**
- **Irving – Community Council of Greater Dallas**
- **McKinney-Avenues Counseling Center**
- **Irving-TAPPPS**

**The State and DANSA have also engaged in numerous community outreach activities with advocacy organizations, government officials, non-network providers, physical health providers and organizations.**

2._X_ **Administration of Enrollment Process**:

(a)__ State staff conduct the enrollment process.

(b)_X_The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities. The State must request the authority in 1915(b)(2) in Section A.I.b.1. (Refer to Section 2105 of the State Medicaid Manual)

i. Broker name: _**MAXIMUS, Inc**._
ii. Procurement method:
(A). _X__Competitive
(B). ____Sole source
iii. Please list the functions that the contractor will

perform:
**MAXIMUS assists Medicaid clients enrolling in Medicaid managed care and in selecting managed care options. To perform this function MAXIMUS receives a list of Medicaid clients who are to enroll in NorthSTAR. MAXIMUS then provides education and enrollment materials and activities to assist eligible individuals in understanding managed care and the services and choices available to them under NorthSTAR. MAXIMUS provides enrollment materials through the mail and processes all enrollment requests. MAXIMUS operates the information interfaces required both to record enrollment decisions in SAVERR, the State's Medicaid eligibility system, and provides a list of enrollees to the BHO.**

**MAXIMUS also provides corresponding services with respect to the on-going enrollment, disenrollment, and re-enrollment activity of eligible individuals. MAXIMUS maintains a help line to enroll eligible individuals and to respond to inquiries relating to the administration of managed care programs.**

(c)__ State allows MCOs/PIHPs/PAHPs to enroll beneficiaries. Please describe the process and the State's monitoring.

3. **Enrollment Requirement:** Enrollment in the program is:

(a)_X_Mandatory for populations in Section A.III.d

(b)__ Voluntary -- See Cost-effectiveness Section D introduction for instructions on inclusion of costs and enrollment numbers (please describe populations for whom it will be voluntary):

(c)___ Other (please describe):

4. **Enrollment:**

(a)_X_The State will make counseling regarding their MCO/PIHP/PAHP choices prior to the selection of their plan available to potential enrollees. Please describe location and accessibility of sites for face-to-face meetings and availability of telephone access to enrollment selection counseling staff, the counseling process, and information provided to potential enrollees.

**MAXIMUS will continue to provide educational/informational materials to eligible individuals and to the public and to process enrollments into NorthSTAR. MAXIMUS will also assist eligible individuals in locating providers within the provider network that can best serve their needs.**

**New applicants for Medicaid will be given a brief presentation and informational materials describing how to appropriately access services under the managed care system, including the appropriate use of emergency rooms and behavioral health services, either during enrollment through contact with the Enrollment Broker in a Medicaid eligibility office, or during the BHO's initial contact/welcome orientation with the client.**

**Enrollment will take place in one of three ways: (a) the client may call the Enrollment Broker's toll-free telephone number identified in the enrollment brochure; (b) the individual may mail in their enrollment form in the self-addressed, postage paid envelope provided; or (c) the individual may enroll in person at an enrollment presentation, at a local Texas Department of Human Services (TDHS) eligibility office, or at other community facilities which the State may elect to use.**

**The majority of initial enrollments are completed through the Enrollment Broker's toll-free telephone number.**

(b)_X_Enrollment selection counselors will have information and training to assist special populations and persons with special health care needs in selecting appropriate MCO/PIHPs/PAHPs and providers based on their medical needs. Please describe.

**MAXIMUS provides training for their personnel to assist special populations as provided by the MAXIMUS Training Manual.**

(c)_X_Enrollees will notify the State/enrollment broker of their choice of plan by:

i. _X_ mail
ii._X_ phone
iii._X_ in person at **_an enrollment fair or if requested by a home visit._**
iv.___ other (please describe):

**The State was granted permission by CMS to operate with a single contracted BHO with the approval of the waiver submission beginning November 1, 2001 and ending October 31, 2003.**

(d)_X_[Required] There will be an open enrollment period during which the MCO/PIHP/PAHP will accept individuals who are eligible to enroll. Please describe how long the open enrollment period is and how often beneficiaries are offered open enrollment. Please note if the open enrollment period is continuous (i.e., there is no enrollment lock-in period).
**There is a continuous open enrollment period**

(e)_X_Newly eligible beneficiaries will receive initial notification of the requirement to enroll into the program. Please describe the initial notification process.
**MAXIMUS mails an enrollment kit to all newly eligible individuals. The kit contains information about the NorthSTAR program and provides a toll free number that the individual may use to ask questions.**

(f)___ Mass enrollments are expected. Please describe the initial enrollment time frames or phase-in requirements:

(g)_X_If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.
**The State was granted permission by CMS to operate with a single contracted BHO with the approval of the waiver submission beginning November 1, 2001 and ending October 31, 2003. Additionally, the State further requests CMS permission to operate with a single contracted BHO for the duration of the waiver period beginning November 6, 2003 ending November 5, 2005.**

**All enrollees are auto-enrolled.**

i. Potential enrollees will have____days/month(s) to choose a plan.
ii. Please describe the auto-assignment process and/or algorithm. What factors are considered? Does the auto-assignment process assign persons with special health care needs to an MCO/PIHP/PAHP that includes their current provider or to an MCO/PIHP/PAHP that is capable of serving their particular needs?

(h) __ The State provides guaranteed eligibility of ____ months for all MCO enrollees under the State plan. How and at which point(s) in time are potential enrollees notified of this?

(i)__ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP. Please describe the circumstances under which an enrollee would be eligible for exemption from enrollment. In addition, please describe the exemption process:

5. **Disenrollment:**

(a)__ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs.

i. ___ Enrollee submits request to State

ii. ___ Enrollee submits request to MCO/PIHP/PAHP. The plan may approve the request, or refer it to the State plan may not disapprove the request).

iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP grievance procedure before determination will be made on disenrollment request

iv. ___ [Required] Regardless of whether plan or State makes determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

(b)__The State does not allow enrollees to disenroll from the only available PIHP/PAHP.

**The State was granted permission by CMS to operate with a single contracted BHO with the approval of the waiver submission beginning November 1, 2001 and ending October 31, 2003. Medicaid enrollees can not disenroll from NorthSTAR.**

(c)_X_The State monitors and tracks disenrollments and transfers between MCOs/PIHPs/PAHPs. Please describe the tracking and analysis:

**The State was granted permission by CMS to operate with a single contracted BHO with the approval of the waiver submission beginning November 1, 2001 and ending October 31, 2003.**

**The State directly authorizes all disenrollments of Medicaid eligible individuals (other than for individuals who move out of the service area r otherwise become ineligible for Medicaid or the NorthSTAR program). To date, the State has not received any requests for the involuntary disenrollment of a Medicaid eligible individual.**

(d)__ The State has a lock-in period of ____ months (up to 12 months permitted). If so, the following are required:

i.___ MCO/PIHP/PAHP enrollees must be permitted to disenroll without cause within the first 90 days of each enrollment period with each MCO/PIHP/PAHP.

ii.___ MCO/PIHP/PAHP enrollees must be notified of their ability to disenroll or change MCOs/PIHPs/PAHPs at the end of their enrollment period at least 60 days before the end of that period.

iii.___ MCO/PIHP/PAHP enrollees who have the following good cause reasons for disenrollment are allowed to disenroll during the lock-in period:

A. __ [Required] Enrollee moves out of plan area

B. ___[Required] Plan does not, because of moral or religious objections, cover the service the enrollee seeks

C. ___[Required] Enrollee needs related services; not all services available in network, and enrollee's provider determines that receiving services separately would subject enrollee to unnecessary risk

D. ___ [Required] Poor quality of care

E. __ [Required] Lack of access to covered services

F. __ [Required] Lack of access to providers experienced in dealing with enrollee's health care needs

G. ___ Other: (please list)

iv. __ [Required] Ensure access to State fair hearing process for any enrollee dissatisfied with determination that there is not good cause for disenrollment.

(e)__ The State does not have a lock-in, and enrollees in MCOs/PIHPs/PAHPs are allowed to terminate or change their enrollment without cause at any time.

(e) _X_ [Optional] A beneficiary who is disenrolled from an MCO/PIHP/PAHP solely due to loss of eligibility for two months or less may be automatically re-enrolled with the same MCO/PIHP/PAHP.

**All Medicaid enrollees who lose Medicaid eligibility and regain their eligibility within 180 days will be automatically re-enrolled in the single BHO.**

6. **MCO/PIHP/PAHP Disenrollment of Enrollees**: If the State permits MCOs/PIHPs/PAHPs to request disenrollment of enrollees, please check items below that apply:

(a)_X_[Required] The MCO/PIHP/PAHP can request to disenroll or transfer enrollment of an enrollee to another plan. If so, it is important that reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status, utilization of medical services, diminished mental capacity, and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee. Please describe the reasons for which the MCO/PIHP/PAHP can request reassignment of an enrollee:

**The BHO may request disenrollment of a Medicaid eligible enrollee against his or her will under limited conditions. These conditions include, but are not limited to:**

**(a) Severe disruptive behavior not caused by a behavioral health condition at a network provider's office;**

**(b) Fraudulent loaning of the Enrollee's Medicaid identification card to another person**

**The BHO may <u>not</u> request a disenrollment based on any of the following:**

**a) An adverse change in the Enrollee's health or behavioral health status;**

**(b) Utilization of medically necessary services;**

**(c) Enrollee's race, color, national origin, sex, age, disability, political beliefs or religion, or**

**(d) Enrollee's disruptive behavior is due to a behavioral health or physical health condition.**

**Prior to exercising a right to disenroll an Enrollee the BHO must:**

**(a) Document that necessary steps have been taken to educate the Enrollee regarding the conditions for disenrollment. If an Enrollee exhibits disruptive behavior, the BHO must work with the Enrollee and his family, as appropriate, to develop a plan to address the disruptive behavior prior to requesting disenrollment of the Enrollee.**

(b)_X_The State reviews and approves all MCO/PIHP/PAHP-initiated requests for enrollee transfers or disenrollments.

(c)_X_If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP to remove the enrollee from its

membership.

(d)__ The enrollee remains a member of the MCO/PIHP/PAHP until another MCO/PIHP/PAHP is chosen or assigned.

**c. Entity Type Or Specific Waiver Requirements**

**Upcoming Waiver Period** -- Please describe the entity type or specific waiver requirements for the upcoming two-year period.

1._X_ **Required MCO/PIHP/PAHP Elements:** MCOs/PIHPs/PAHPs will be required to comply with all applicable federal statutory and regulatory requirements, including those in Section 1903(m) and 1932 of the Act, and 42 CFR Parts 434 and 438 et seq.

2. **Required Elements Relating to Waiver under Section 1915(b)(4):** If the State is requesting authority under Section 1915(b)(4) of the Social Security Act, please mark the items that the State is in compliance with:

(a)_X_ The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

i._X__ Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in your State's Medicaid State Plan.

ii._X_ MCO/PIHP/PAHP must provide or arrange to provide for the full range of Medicaid services to be provided under the waiver.

iii._X__MCO/PIHP/PAHP must agree to accept as payment the reimbursement rate set by the State as payment in full.

iv.___ Per 42 CFR 431.55(f)(2)(i), enrollees residing at a long term care facility are not subject to a restriction of freedom of choice based on this waiver authority unless the State arranges for reasonable and adequate enrollee transfer.

v._X_ There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in

providing services.

3. The State has selected/will select the MCOs/PIHPs/PAHPs that will operate under the waiver in the following manner:

(a)_X_The State has used/will use a competitive procurement process. Please describe.

**The competitive procurement process was initiated in June 1998, with the issuance of a Request for Application (RFA). Five formal responses to the RFA were received and each response was scored against a specific set of criteria. As a result of this process, Magellan Behavioral Health, Inc. and ValueOptions were tentatively selected for participation in NorthSTAR subject to the successful completion of contract negotiations and readiness review. Prior to implementation, both organizations completed contract negotiations and passed all readiness review requirements. On June 30, 2000, the State received official notification from Magellan that they would not be renewing the contract for a second year. Magellan did agree to continue to provide services to enrollees during a sixty day transition period which would ended on September 30, 2000, ValueOptions began providing services to all NorthSTAR recipients on October 1, 2000, and has continued to provide services to the entire NorthSTAR population since that date**

(b)__ The State has used/will use an open cooperative. procurement process in which any qualifying MCO/PIHP/PAHP may participate that complies with federal procurement requirements and 45 CFR Section 74

(c)__ The State has not used a competitive or open procurement process. Please explain how the State's selection process is consistent with federal procurement regulations, including 45 CFR Section 74.43 which requires States to conduct all procurement transactions in a manner to provide to the maximum extent practical, open and free competition.

4._X_ Per Section 1932(d) of the Act and 42 CFR 438.58, the State has conflict of interest safeguards with respect to its officers and employees who have responsibilities related to MCO/PIHP/PAHP contracts and the default enrollment process established for MCOs/PIHPs/PAHPs.

**d. Services**

**Previous Waiver Period**

1._X_ [Required for all elements checked in the previous waiver submittal] Please provide a description of how often and through what means the State has monitored compliance with service provision requirements. Please include the results from those monitoring efforts for the previous waiver period. [Reference: items A.III.d.2-6 of the 1999 initial preprint; items A.13, 14, 21 of the 1995 preprint, items A.III.d. Upcoming Waiver Period of 9/23/99 Waiver Renewal Preprint]

**NorthSTAR does not provide general physical health care, family planning, vision-related or FQHC services. The State has developed and implemented systematic monitoring processes to monitor compliance with all behavioral health service provision requirements. This has included assigning specific State staff to three areas, i.e. contract management, quality improvement and consumer/provider relations. These staff have worked in a complementary fashion to attend various BHO operational meetings and stakeholder meetings where the ability of the BHO to operationalize the contract are consistently reviewed and discussed. Additionally these staff have provided ad hoc provider site visits to determine compliance with a variety of access and/or contract related provisions such as the BHO adherence to medical necessity criteria and monitoring of the timeliness of the authorization process. This has resulted in a consistently visible State level presence at both the BHO as well as provider sites. This has particularly included on-site visits to emergency rooms, on-site participation in hospital continuity of care activities and on-site visits to both new and traditional providers in the specialty network. These on-site visits have also included review of relevant medical records by State NorthSTAR staff as well as staff from the TDMHMR Quality Management Divisions.**

**To complement these activities and provide an early warning system, all behavioral health care services (including emergent, urgent and routine services) are monitored by the state through performance data, which is distributed to stakeholders on a monthly basis. (DANSA also compiles and distributes performance data.) The State also monitors service provision through regular (monthly or more frequent) reviews of complaint data and through targeted on-site visits to NorthSTAR BHO network providers. The State tracks the status and disposition of all complaints to determine if the BHO (or any provider in the network) is out of compliance with the service provision guidelines.**

**To date the State has not detected any significant level of non-compliance with established service provision guidelines. The State intervenes directly to assure that consumer complaints are resolved in**

**a timely and effective manner. As the State gains experience both in managing the NorthSTAR system and in utilizing the information management tools available within the State's data warehouse, the State is developing a greater level of sophistication in identifying potential problems and in selecting specific providers for on-site reviews.**

**Upcoming Waiver Period** -- Please describe the service-related requirements for the upcoming two year period.

1._X__Please list in Appendix D.2.S the Medicaid services MCOs/PIHPs/PAHPs will be responsible for delivering, prescribing, or referring. Instructions for this Appendix can be found in Section D. Cost Effectiveness, III. Instructions for Appendices.

2. **Emergency Services (Required)**. The State must ensure enrollees in MCOs/PIHPs/PAHPs have access to emergency services without prior authorization even if the emergency provider does not have a contractual relationship with the entity. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

   (a)_X_The State has a more stringent ***(behavioral health specific)*** definition of emergency medical condition for MCOs/PIHPs/PAHPs than the definition above. Please describe.

   **The State has adopted a prudent layperson definition for emergency behavioral health condition which is defined as:** "**Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent lay person possessing an average knowledge of medicine and health, requires immediate intervention and/or medical attention without which an individual would present a danger to themselves or others or which renders individuals incapable of controlling, knowing or understanding the consequences of their actions."**

   The State takes the following required steps to ensure access to emergency services. If an item below is not checked, please explain.

(b)_X_ The State ensures enrollee access to emergency services by requiring the MCO/PIHP/PAHP to provide adequate information to all enrollees regarding emergency service access (see Section H. Enrollee Information and Rights)

(c)_X_ The State ensures enrollee access to emergency services by including in the contract with MCOs/PIHPs/PAHPs a requirement to cover and pay for the following: *Please note that this requirement for coverage does not stipulate how, or if, payment will be made. States may give MCOs/PIHPs/PAHPs the flexibility to develop their own payment mechanisms, e.g. separate fee for screen/evaluation and stabilization, bundled payment for both, etc.*

i.___ For the screen/evaluation and all medically necessary emergency services when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,
NorthSTAR provides emergency behavioral health services only. Members referred for physical health emergencies are evaluated and treated by the appropriate hospital medical staff.

ii._X_ The screen/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

iii._X_ Subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

iv._X_ Continued emergency services until the enrollee can be safely discharged or transferred,

v._X_ Post-stabilization services which are pre-authorized by the MCO/PIHP/PAHP, or were not pre-authorized, but the MCO/PIHP/PAHP failed to respond to request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the MCO/PIHP/PAHP contacts the emergency room and takes responsibility for the enrollee.

**NorthSTAR does not offer physical health emergency services.**

(d) The State also assures the following additional requirements are met:

i._X_ The MCO/PIHP/PAHP may not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms;

ii. _X_ The MCO/PIHP/PAHP may not refuse to cover emergency services based on the provider not notifying the enrollee's PCP or plan of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services;

iii. _X_ The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO/PIHP/PAHP.

(e) ___ The MCO/PIHP/PAHP does not cover emergency services.

2. **Family Planning**: In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's PCP (or other MCO/PIHP/PAHP staff), or requiring the use of participating providers for family planning services is prohibited under the waiver program.
**NorthSTAR is a behavioral health carve out, as such it does not offer family planning services.**

(a)__ Enrollees are informed that family planning services will not be restricted under the waiver.

(b)__ Non-network family planning services are reimbursed in the following manner:

i.___ The MCO/PIHP/PAHP will be required to reimburse non-network family planning services

ii.___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from non-network providers

iii.___The State will pay for all family planning services, provided by both network as well as non-network providers

iv.___ The State pays for non-network services and capitated rates were set accordingly.

v.___ Other (please explain):

(c) _X_ Family planning services are not included under the waiver.
**NorthSTAR is a behavioral health carve out, as such it does not offer family planning services.**

3. **Other Services to Which Enrollee Can Self-Refer**: In addition to emergency care and family planning, the State requires MCOs/PIHPs/PAHPs to allow enrollees to self-refer (i.e. access without prior authorization)under the following circumstances or to the following services:
**The BHO provides emergency services (including mobile crisis services) without prior authorization.**

**The State gives the BHO latitude to set pre-authorization requirements for all non-emergency services. Value Options has elected to relax certain pre-authorization requirements for several services where medical necessity has been determined by the provider:**

- **For routine outpatient, 10 units per enrollee can be delivered without pre-authorization (individual and group counseling).**

- **For supportive outpatient for CD services, 20 units per enrollee can be delivered without pre-authorization.**

(a) ___ [Required for rural exception to choice]

- The service or type of provider is not available in the plan;
- for up to 60 days if provider is not part of the network but is the main source of care and is given opportunity to join network but declines;
- MCO/PIHP/PAHP or provider does not, because of moral or religious objections, provide a covered service; provider determines enrollee needs related service not available in network and receiving service separately

would subject enrollee to unnecessary risk.

(b) ___ [Required if women's routine` and preventive care is a covered service] Female enrollees must have direct access to women's health specialist within the network for covered care related to women's routine and preventive care. (Please note whether self-referral is allowed only to network providers or also to non-network providers.)

(c) ___ Other: (please identify)

5._X_ **Monitoring Self-Referral Services**. The State places the following requirements on the MCO/PIHP/PAHP to track, coordinate, and monitor services to which an enrollee can self-refer:
**Medicaid eligible individuals can access Emergency services without any prior authorization. The State gives the BHO latitude to set pre-authorization requirements for all non-emergency services.**

**The State requires the BHO to provide enrollees with information about how to access emergency services in the Enrollee Information Handbook, which the State reviews and approves. State monitoring involves review of utilization data, as well as review of monthly client complaint data from all sources. The BHO's data system is also required to support tracking utilization control function(s) and monitor inpatient admissions, emergency room use, ancillary, and out-of-area services. The system must also support developing provider profiles and occurrence reporting.**

6. **Federally Qualified Health Center** (FQHC) Services will be made available to enrollees under the waiver in the following manner (indicate one of the following, and if the State's methodology differs, please explain in detail below):

(a)__ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP is not required to provide FQHC services to the enrollee during the enrollment period.

(b)__ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP which has at least one FQHC as a participating provider. If the enrollee elects not to select the MCO/PIHP/PAHP that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP he or she selected. In any event, since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available.

Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP with a participating FQHC:

(c)_X_The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

7. **EPSDT Services:** The State has coordinated and monitored EPSDT services under the waiver program as follows:

(a) __ The State requires MCOs/PIHPs/PAHPs to report EPSDT screening data, including behavioral health data (e.g., detailed health and development history including physical and mental health assessments). Please describe the type and frequency of data required by the State.

(b)__ EPSDT screens are covered under this waiver. Please list the State's EPSDT annual screening rates, including behavioral components, for previous waiver period. (Please note*: CMS requested that each State obtain a baseline of EPSDT and immunization data in the initial application. That baseline could have been the data reported in the CMS 416 report or it may be rates/measures more specific to the Medicaid managed care population. Those rates from the previous submission should be compared to the current rates and the reports listed here.) Please describe whether screening rates increased or decreased in the previous waiver period and which activities the State will undertake to improve the percentage of screens administered for enrollees under the waiver.

(c) __ Immunizations are covered under this waiver. Please list the State's immunization rates for previous waiver period. What activities will the State initiate to improve immunization rates for enrollees under the waiver?

(d)__Immunizations are covered under this waiver, and managed care providers are required to enroll in the Vaccines for Children Program. If not, please explain.
**NorthSTAR does not provide physical health services such as immunizations/vaccines or EPSDT screenings (these services are covered under the physical health managed care (STAR) program). BHO providers are contractually required to refer enrollees to their STAR health plan or to the regular Medicaid**

**program for EPSDT physical health services.**

**Additionally, the NorthSTAR BHO is required to cooperate and coordinate with THSteps (EPSDT) regional program staff and agents to ensure prompt delivery of services to children served by the Texas Department of Protective and Regulatory Services.**

(e)_X_Mechanisms are in place to coordinate school services with those provided by the MCO/PIHP/PAHP. Please describe and clarify the aspects of school services that are coordinated including IEPs, IFSPs, special education requirements, and school-based or school-linked health centers (e.g., plan requirements for PCP cooperation or involvement in the development of the IEPs).

- **BHO staffs have participated in a number of Health Fairs, enrollment events and activities held at the various school districts.**
- **The BHO has incorporated specific information into provider training sessions that emphasize the importance of bringing all caregivers and stakeholders to the table to discuss the child's treatment. Difficult cases are discussed with the treatment team and representatives from the school districts often attend these case conferences at the Provider's location.**
- **During case conferences, the IEP and educational requirements are discussed.**
- **In an innovative approach to serving children within Dallas County, the BHO has included a number of Dallas Independent School District (DISD) school counselors within its network. There is a Psychiatrist and several counselors in the schools who are contracted with the BHO and provide direct services to NorthSTAR consumers. The school counselors often provide psychological testing, on-site medication management, on-site individual, family or group therapy in some schools.**
- **The Children's Mental Health Committee consists of Child Community Providers, Consumer (child) advocates, Child Protective Services, Juvenile Justice, School Systems, DANSA and ValueOptions. This committee addresses the common MH/CD needs of children in the community and advocates for system change. Prevention, screening and access issues are often the topic of discussion. One current project includes trying to find creative ways to keep children engaged in treatment. A number of schools have offered space and locations for treatment providers and the provider contract does pay providers to do therapy on site**

**in the schools. Also under discussion is the use of after-school programs as sites for therapy.**

- **BHO staff also participates in the monthly CRCG (Community Resource Coordination Group – for children) for all seven counties. CRCG hold monthly meetings to discuss the most difficult of the cases. Community Providers, BHO Care Management Staff, DANSA and school staff participate. Most often the families also attend and a comprehensive plan is developed.**

(f)_X_ Mechanisms are in place to coordinate other aspects of EPSDT (e.g., dental, mental, Title V, etc) with those provided by the MCO/PIHP/PAHP. Please describe.

**The BHO is required to ensure that providers assess the physical health needs of enrollees during intake, assessment and treatment. Any enrollee who is determined to have a physical health care need or who has not recently had a physical health check up is referred to the STAR Primary Care Physician (PCP).**

**BHO and STAR HMO providers have also been required to develop strategies that ensure that referrals to behavioral health care as a result of findings from the EPSDT (THSteps) screens are given special priority for timely access and follow up.**

**Furthermore, the BHO is contractually required to coordinate care with physical health care plans participating in State's physical health (STAR) program and to enter into written agreements with Community Resource Coordination Groups (CRCGs) for service planning. CRCGs address the issue of coordinated service planning for children on the individual or "micro" level. CRCGs include representatives from the Texas Department of Protective and Regulatory Services (TDPRS), the Texas Commission for the Blind (TCB), the Texas Department of Health (TDH) which is the Title V agency, the Texas Department of Human Services (TDHS), the Texas Department of Mental Health and Mental Retardation (TDMHMR), the Texas Education Agency (TEA), the Texas Interagency Council on Early Childhood Intervention (ECI), the Texas Juvenile Probation Commission (TJPC), the Texas Rehabilitation Commission (TRC), the Texas Commission on Alcohol and Drug Abuse, and the Texas Youth Commission (TYC). These agency representatives, as well as representatives from a number of other private and public agencies, come together to develop individualized coordinated service plans for children and adolescents whose needs can be met only through interagency**

**coordination and cooperation.**

**Each regional CRCG team meets regularly (as often as twice per month) to address the service coordination needs of individual children and adolescents who are involved with, or receiving services from, multiple agencies. To assure a comprehensive and coordinated approach to treatment for children enrolled in NorthSTAR, the State contractually mandates that the BHO enter into written agreements with local CRCGs for service planning.**

**Section B. ACCESS AND CAPACITY**

A Section 1915(b) waiver program serves to improve an enrollee's access to quality medical services. A waiver must assure that services provided are of adequate amount, are provided within reasonable time frames, and are furnished within a reasonable distance from the residences of the enrollees in the program. Furthermore, the proposed waiver program must not substantially impair access to services and access to emergency and family planning services must not be restricted.

## I. Timely Access Standards

**Upcoming Waiver Period** -- Please describe the State's availability standards for the upcoming waiver period.

**a.** **Availability Standards**: The State has established maximum distance and/or travel time requirements, given clients' normal means of transportation, for MCO/PIHP/PAHP enrollees' access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2._X_ Specialists (please describe your standard):
**The NorthSTAR BHO is contractually obligated to ensure enrollees are not required to travel distances in excess of 30 miles to obtain non-hospital/ non-residential services.**

3._X_ Ancillary providers (please describe your standard):
**The NorthSTAR BHO is contractually obligated to ensure enrollees are not required to travel distances in excess of 30 miles to obtain non-hospital/ non-residential services.**

4.___ Pharmacies (please describe your standard):

5._X_ Hospitals (please describe your standard):
**The NorthSTAR BHO is contractually obligated to ensure enrollees are not required to travel distances in excess of 75 miles to obtain psychiatric hospital services.**

6._X_ Mental Health (please describe your standard):
**The NorthSTAR BHO is contractually obligated to ensure enrollees are not required to travel in excess of 30 miles to secure covered services, with the exception of psychiatric hospitalization, 24-hour residential rehabilitation and inpatient detoxification services, for which enrollees**

**may not be required to travel in excess of 75 miles.**

7._X_ Substance Abuse Treatment Providers (please describe your standard):
**The NorthSTAR BHO is contractually obligated to ensure enrollees are not required to travel in excess of 30 miles to secure covered services, with the exception of psychiatric hospitalization, 24-hour residential rehabilitation and inpatient detoxification services, for which Enrollees may not be required to travel in excess of 75 miles.**

8.___ Dental (please describe your standard):

9.___ Other providers (please describe your standard):

**b. Appointment Scheduling** (Appointment scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits.) The State has established standards for appointment scheduling for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5._X_ Hospitals (please describe your standard):

6._X_Mental Health (please describe your standard):

7._X_ Substance Abuse Treatment Providers (please describe your standard):

8.___ Dental (please describe your standard):

9._X_ Urgent care (please describe your standard):

10.___Other providers (please describe your standard):
**NorthSTAR uses a uniform access standard for <u>all</u> provider types. The BHO must arrange for covered services within the following time periods:**
**a) Emergency behavioral health services: immediately;**
**b) Urgent Care: within 24 hours of request, including transfer between**

**levels of care during a chemical dependency episode;**

**c) Routine Care: within 14 calendar days of request.**

**c. In-Office Waiting Times:** The State has established standards for in-office waiting times for MCO/PIHP/PAHP enrollee's access to the following. Check any that apply (1-9). For each item checked, please describe the standard and answer monitoring questions in B.II.

1.___ PCPs (please describe your standard):

2.___ Specialists (please describe your standard):

3.___ Ancillary providers (please describe your standard):

4.___ Pharmacies (please describe your standard):

5._X_ Hospitals (please describe your standard):
**The State requires the BHO to develop, implement and maintain procedures to monitor waiting times in provider's offices and in obtaining various types of appointments.**

6._X_ Mental Health (please describe your standard):
**The State requires the BHO to develop, implement and maintain procedures to monitor waiting times in provider's offices and in obtaining various types of appointments.**

7._X_ Substance Abuse Treatment Providers (please describe your standard):
**The State requires the BHO to develop, implement and maintain procedures to monitor waiting times in provider's offices and in obtaining various types of appointments.**

8.___ Dental (please describe your standard):

9.__ Other providers (please describe your standard):

**II. Access and Availability Monitoring:** Enrollee access to care will be monitored by the State, as part of each MCO/PIHP/PAHP's Quality Assessment and Performance Improvement program, annual external quality review (EQR), and (if applicable) Independent Assessments (IA).

**Previous Waiver Period**

**a._X_** [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP access and availability in the previous two year period. [item B.II in the 1999 initial

preprint; items B.4, 5, and 6 in the 1995 preprint; item B.II Upcoming Waiver Period, 9/23/99 Waiver Renewal Preprint].
**State monitoring of access has been carried out through the tracking and regular review of complaint reports, on-site visits, test calls and through the distribution of a member satisfaction survey to a sample of individuals served through the NorthSTAR program.**

**Upcoming Waiver Period** -- Check below any of the following (a-o) that the State will also utilize to monitor access:

**a.**_X_ Measurement of access to services during and after a MCO/PIHP/PAHP's regular office hours to assure 24 hour accessibility, 7 days a week (e.g., PCPs' 24-hour accessibility will be monitored through random calls to PCPs during regular and after office hours)

**b.**___ Determination of enrollee knowledge on the use of managed care programs

**c.**_X_ Ensure that services are provided in a culturally competent manner to all enrollees, and the MCO/PIHP/PAHP participates in any State efforts to promote the delivery of services in a culturally competent manner.

**d.**_X_ Review of access to emergency or family planning services without prior authorization

**e.**_X_ Review of denials of referral requests
**Denials of referral requests are tracked through review of adverse determinations, appeals and denials. The State also tracks complaint reports and utilizes member satisfaction surveys. The BHO must, as part of its Quality Improvement Program, develop systems to clearly document and notify an enrollee of reasons for denial, termination or other limitation of a covered health care service, including information about the BHO's complaint and appeal process.**

**f.**___ Review of the number and/or frequency of visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.

**g.**_X_ Periodic enrollee experience surveys (which includes questions concerning the enrollees' access to all services covered under the waiver) will be mailed to a sample of enrollees. Corrective actions taken on deficiencies found are also planned.

**h.**___ Measurement of enrollee requests for disenrollment from a MCO/PIHP/PAHP due to access issues

**i.**_X_ Tracking of complaints/grievances concerning access issues

**j.**_X_ Geographic Mapping detailing the provider network against beneficiary locations will be used to evaluation network adequacy. (Please explain)
**The State requests and receives geo access maps on an ad hoc basis; the State has evaluated client access on multiple occasions previously and found access to be within contractual requirements. The State receives provider network change reports on a monthly basis. The network has not contracted substantially within the last waiver period per the provider network change reports. Any indications of provider inadequacy will initiate analysis of client geo access.**

**k.**___ Monitoring access to prescriptions on the State Plan Formulary, Durable Medical Equipment, and therapies.

**l.** During monitoring, the State will look for the following indications of access problems.

1._X_ Long waiting periods to obtain services from a PCP.
**NorthSTAR is a BHO and as such does not have PCPs. Provider access is monitored through geo access maps submitted to the State on an contractually required quarterly basis as requested basis.**
2._X_ Denial of referral requests when enrollees believe referrals to specialists are medically necessary.
3._X_ Enrollee confusion about how to obtain services not covered under the waiver.
4._X_ Lack of access to services after PCP's regular office hours.
5._X_ Inappropriate visits to emergency rooms, non-authorized visits to specialists, etc., for medical care.
6._X_ Lack of access to emergency or family planning services.
7.__ Frequent recipient requests to change a specific PCP.
8._X_ Other indications (please describe):
**Additionally the State monitors access through the enrollee complaint monitoring system.**

**m.**__ Monitoring the provision and payment for transportation for beneficiaries to get to their outpatient, medically necessary mental health services.

**n.**_X_ Monitoring the provider network showing that there will be providers within the distance/travel times standards.

**o.**__ The incentives, sanctions, and enforcement related to the access and availability standards above.

**p.**___ Other (please explain):

## III. Capacity Standards

**Previous Waiver Period**

**a.**__X_[Required] MCO/PIHP/PAHP Capacity Standards. The State ensured that the number of providers under the waiver remained adequate to assure access to all services covered under the contract. Please describe the results of this monitoring.

**The State receives monthly reports from the BHO detailing the additions and/or deletions of the provider network. This data is used to gauge the current capacity of the network. The BHO supplies geo access maps on request to assess compliance with travel distance requirements. The data indicates that the provider network has remained relatively complete in the number and diversity of providers.**

b.___ [Required if elements III.a.1 and III.a.2 were marked in the previous waiver submittal] The State has monitored to ensure that enrollment limits and open panels were adequate. Please describe the results of this monitoring.

**Upcoming Waiver Period** -- Please describe the capacity standards for the upcoming two year period.

**a. MCO/PIHP/PAHP Capacity Standards**

1.___ The State has set enrollment limits for the MCO/PIHP/PAHPs. Please describe a) the enrollment limits and how each is determined and b) a description of how often and through what means the limits are monitored and changed.

2.___ The State monitors to ensure that there are adequate open panels within the MCO/PIHP/PAHP. Please describe how often and how the monitoring takes place.

3._X_ [Required] The State ensures that the number of providers under the waiver is adequate to assure access to all services covered under the contract. Please describe how the State will ensure that provider capacity will be adequate.

**The State will continue to monitor network composition on a monthly basis. If for any reason the network capacity does not meet or exceed that standard, the State will implement appropriate sanctions in order to assure compliance with access requirements.**

**b. PCP Capacity Standards**

**N/A - NorthSTAR is a behavioral health "carve-out", as such no PCPs are utilized in the NorthSTAR program.**

1.___ The State has set capacity standards for PCPs within the

MCO/PIHP/PAHP expressed in the following terms (In the case of a PIHP/PAHP, a PCP may be defined as a case manager or gatekeeper):

i.___ PCP to enrollee ratio
ii.___ Maximum PCP capacity
iii.__ For PCP contracts with multiple plans, please describe any efforts the State is making to monitor unduplicated Medicaid enrollment capacity across plans

2.___ The State ensures adequate geographic distribution of PCPs within MCO/PIHPs/PAHPs. Please explain.

3.___ The State designates the type of providers that can serve as PCPs. Please list these provider types.

**c. Specialist Capacity Standards**

**Because NorthSTAR is a specialty "carve out", the entire network is specialized in the provision of behavioral health services. Nonetheless, the State has required the BHO to establish a sub-network (or sub-networks) of specialty providers that have experience in providing services to adults with severe and persistent mental illness and children with serious emotional disturbance. These specialty provider networks (SPNs) have as their primary focus the delivery of wrap-around services such as psychiatric rehabilitation services, assertive community treatment (ACT) services, and targeted case management to individuals with multiple needs and or have difficulty in remaining engaged in treatment.**

1.___ The State has set capacity standards for specialty services. Please explain.

2._X_ The State requires particular specialist types to be included in the MCO/PIHP/PAHP network. Please identify these in the chart below, modifying the chart as necessary to reflect the specialists in your State's waiver. Please describe the standard if applicable, e.g. specialty to enrollee ratio. If specialists types are not involved in the MCO/PIHP/PAHP network, please describe how arrangements are made for enrollees to access these services (for waiver covered services only).

| Specialist Provider Type | Adult | Pediatric | Standards |
|---|---|---|---|
| Addictionologist and/or Certified Addiction Counselors | **X** | | |
| | | | |

| Specialist Provider Type | Adult | Pediatric | Standards |
|---|---|---|---|
| Allergist/Immunologist | | | |
| Cardiologist | | | |
| Chiropractors | | | |
| Dentist | | | |
| Dermatologist | | | |
| Emergency Medicine specialist | | | |
| Endocrinologist | | | |
| Gastroenterologist | | | |
| Hematologist | | | |
| Infectious/Parasitic Disease Specialist | | | |
| Neurologist | | | |
| Obstetrician/Gynecologist | | | |
| Oncologist | | | |
| Ophthalmologist | | | |
| Orthopedic Specialist | | | |
| Otolaryngologist | | | |
| Pediatrician | | | |
| Psychiatrist | X | X | Must be in network. |
| Pulmonologist | | | |
| Radiologist | | | |
| Surgeon (General) | | | |
| Surgeon (Specialty) | | | |
| Other mental health providers (please specify) | | | |
| Other dental providers(please specify) | | | |

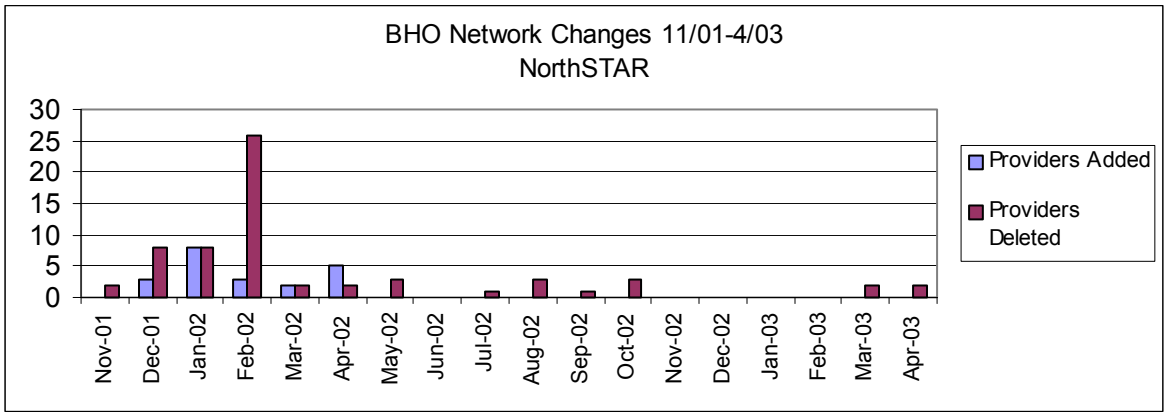
| Specialist Provider Type | Adult | Pediatric | Standards |
|---|---|---|---|
| Other (please specify) | | | |
| Psychologists | X | X | Must be in network |
| Licensed Master Social Workers with Advanced Clinical Practitioner Certification | X | X | Must be in network |
| Licensed Professional Counselors | X | X | Must be in network |
| Licensed Chemical Dependency Counselors | X | X | Must be in network |
| Qualified Credentialed Counselors (QCCs) | X | X | Must be in network |
| Assertive Community Treatment Teams | X | X | Must be in network |

## IV. Capacity Monitoring

**Previous Waiver Period**

**a._X_** [Required for all elements checked in the previous waiver submittal]
**The State has not set capacity standards for any provider type. The State requires the BHO to have a system for monitoring patient load on its provider network so that the BHO can effectively plan for future needs and recruit providers as necessary to assure adequate access to behavioral health care and provide all covered services. The BHO is also required to provide a monthly report to the State detailing the composition of the Network and any changes, which have occurred. The State monitors capacity through a regular review of the BHO network reports and through an on-going review of all complaints received from all sources.**

Please include the results from monitoring the MCO/PIHP/PAHP capacity in the previous two year period [item B.IV in the 1999 initial preprint; items A.15-16 in the 1995 preprint; item B.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint ].




**December 01 to February 2002 spike in providers leaving the network is mainly due to individual providers choosing not to renew their BHO contracts. Many of these individual practitioners treated few, if any NorthSTAR enrollees, and most of these providers were LMSW-ACPs, LPCs, or LMFTs. The BHO continues to have an abundance of these provider types.**

**Upcoming Waiver Period** --
Please indicate which of the following activities the State employs:

**a.**_X_ Periodic comparison of the number and types of Medicaid providers before and after the waiver.

**b.**___ Measurement of referral rates to specialists.

**c.**_X_ Provider-to-enrollee ratios

**d.**_X_ Periodic MCO/PIHP/PAHP reports on provider network

**e.**___ Measurement of enrollee requests for disenrollment from a plan due to capacity issues

**f.**_X_ Tracking of complaints/grievances concerning capacity issues

**g.**___ Geographic Mapping (please explain)

**i.**___ Tracking of termination rates of PCPs

**j.**___ Review of reasons for PCP termination

**k._X_** Consumer Experience Survey, including persons with special needs,

**l.__** Other (Please explain):

## V. Coordination and Continuity of Care Standards

**Upcoming Waiver Period --** Check any of the following that the State requires of the MCO/PIHP/PAHP:

**a.**_X_ Primary Care and Coordination

(i)__ [Required] Implement procedures to deliver primary care to and coordinate health care service for all enrollees.

(ii)__ [Required] Ensure each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity who is primarily responsible for coordinating the enrollee's health care services.

(iii)_X_ [Required] Coordinate the services the MCO/PIHP/PAHP furnishes to the enrollee with services the enrollee receives from any other MCO/PIHP/PAHP.

(iv)_X_ [Required] Ensure that in the process of coordinating care, each enrollees' privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

(v)_X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the primary care requirements of 42 CFR 438.208. Please explain.

**NorthSTAR is a specialty behavioral health "carve-out", and as such does not provide primary care services. The NorthSTAR BHO performs coordination of behavioral health services and physical health care (STAR) HMO services.**

**The care manager group meets regularly to review and monitor care coordination activities. Emphasis is placed on identifying strategies to improve communication between behavioral health providers and primary care physicians. In addition to addressing general care coordination issues, the group also identifies and resolves plan-specific problems when they occur.**

**b.**_X_ Additional services for enrollees with special health care needs.

(i)_X_ [Required] Identification. The state has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

**In addition to identification by Medicaid program and type through the State's enrollment system, the BHO is required to provide a clinical screening for all children who present for services. This screening will be utilized by the clinician to determine the complexity of the child's needs and to help determine if the individual will be best served though the SPN or through other providers in the network. Individuals with multiple or complex needs will be referred to the SPN when clinically indicated. When a child is referred to the SPN, a standardized assessment is performed which more specifically targets behavioral symptomology and functional deficits. This screening/assessment procedure serves to enhance the treatment planning and service delivery process for each child with complex needs.**

**Additionally, the BHO is required to coordinate assessment, treatment, referral, and follow-up services for children who use multiple providers and services, sites and levels of care within the BHO's plan and other agencies or health care plans. Formal coordination agreements and guidelines for the coordination of services have been developed to help ensure that care for individuals with co-occurring physical and behavioral health needs are closely coordinated between the physical health care (STAR) HMOs and the NorthSTAR BHO.**

(ii)_X_ [Required] Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the state to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

**During initial implementation the Enrollment Broker (MAXIMUS) worked closely with the State to develop staff training materials and to ensure that staff were properly trained in addressing the special needs of persons with mental illness. Additionally, MAXIMUS has had significant experience in the State of Michigan in providing enrollment services to children with special needs and they have drawn on this experience in Michigan to provide specific training to its NorthSTAR enrollment counselors. The training is designed to highlight the needs of this special population with emphasis on communication to individuals with special needs. The positive performance of the Enrollment Broker during the previous waiver cycles has demonstrated that this specialized training has been both beneficial and effective. The State will continue to work with the Enrollment Broker to further improve and enhance training during the upcoming waiver cycle.**

**The BHO is contractually required to ensure that a behavioral health**

**assessment and treatment plan is completed within three (3) days of a routine outpatient visit and within 48 hours of an emergency or urgent inpatient or residential placement. The Contractor must update the treatment plan at least weekly for inpatient or residential treatment and every ten (10) visits for Enrollees receiving outpatient services, but not less frequently than every three (3) months.**

(iii)_X_ [Required] Treatment Plans. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1.__Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists care for the enrollee
2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
3.__ In accord with any applicable State quality assurance and utilization review standards.

**As a behavioral health "carve-out", NorthSTAR does not provide primary care services, including the development of primary care treatment plans. Individualized treatment plans formulated to address behavioral health needs are developed by providers in the BHO provider network.**

(iv)_X_ [Required] Direct access to specialists. If treatment plan or regular care monitoring is needed, MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

(v)_X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208.
**NorthSTAR is a specialty behavioral health "carve-out", and as such does not provide primary care services. The NorthSTAR BHO performs coordination of behavioral health services and physical health care (STAR) HMO services.**

## VI. Coordination and Continuity of Care Monitoring

**Previous Waiver Period**

**a.**_X_ [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring continuity and coordination of care in the previous two year period [item B.VI in the 1999 initial preprint;

Section B (as applicable) in 1995 preprint; item B.VI. Upcoming Waiver Period, 1999 Renewal Waiver Preprint.].

**The State's managed care consumers receive physical health care through the State's STAR program and behavioral health care through NorthSTAR. The two programs have worked together to put processes in place to insure the coordination of care between these two systems and to identify successes and weaknesses in the system. The area of care coordination is an on-going process and is part of the overall quality improvement initiatives for the NorthSTAR program.**

**During the initial waiver period, the agencies and providers participating in the NorthSTAR program convened to discuss and clarify their respective areas of responsibility regarding care coordination, as well as to form active workgroups. As a result of this planning process and prior to program implementation an interagency provider workgroup was assembled which included local providers, BHO medical directors, STAR MCO and other NorthSTAR BHO staff as well as state agency staff. This group was charged with developing and implementing guidelines that would facilitate the coordination process. This work resulted in a Memorandum of Understanding (MOU) signed by each of the STAR and NorthSTAR plans that specified the roles and responsibilities of the plans within this delivery system.**

**Once the MOU was signed the group was charged with the implementation of the agreement. In addition, care management staff from STAR and the NorthSTAR plans were designated as liaisons. This care manager group continues to meet regularly to work out the details of care among these organizations.**

**The provider coordination group primarily serves as a policy arm while the care manager group acted as an operations work group. The NorthSTAR TDMHMR/TCADA Quality Manager was designated to be the liaison between these two working groups.**

**The provider group focussed on:**

- **identifying ways to facilitate communication between existing data systems,**
- **identifying and resolving any confidentiality issues relating to sharing information and**
- **attempting to enhance physician communication when patients are shared,**
- **reviewing the Memorandum of Understanding (MOU), to determine that the general principles of the MOU continue to be implemented.**

**Although the group continued to meet through August 2000, much of the work was passed to the care manager group.**

**The care manager group:**

- **developed written procedures related to facilitation of communication between behavioral health specialists and primary care physicians.**
- **began reviewing specific cases where barriers to care coordination emerged and resolved these issues.**

**Early issues raised in the care manager group also helped the state agency to target the EQRO study related to substance abuse in pregnancy. This study specifically looked for the coordination of care provided to this group by both the STAR and the NorthSTAR providers. A follow-up to this study was done by the BHO in SFY 2002 which indicated a substantial increase in the percentage of pregnant women with substance abuse issues who received coordinated behavioral health and physical health care coordination (81% in the follow-up versus 58% in the baseline study). The care manager group and the BHO followed up on results of the first Focused Study on Attention Deficit Hyperactivity Disorder (ADHD), which indicated that PCPs and behavioral health providers treating these children do not consistently communicate. Again, this follow-up study indicated a significant increase in evidence of communication and coordination between physical and behavioral health care providers (68% in the follow-up versus 20% in the baseline study).**

**Since coordinating physical and behavioral health care is a high priority item for the state, review of the expected performance was incorporated into the initial EQRO on-site review. The intent was to provide the state and the plans with an external evaluation of this high priority area. The external evaluation indicated that there were multiple areas for improvement. The BHO and the State worked to incorporate these findings into the Quality Improvement operations.**

**The early planning and work accomplished by the agencies and providers has clearly benefited the NorthSTAR program by laying the groundwork for improving the quality of care delivered to plan members. The care manager group remains active and meets regularly to review and monitor the implementation of care coordination activities, with the ongoing goal of reducing or removing barriers that impede effective care coordination. Emphasis continues to be placed on identifying strategies to improve communication between behavioral health specialists and primary care physicians. In addition to addressing care coordination issues in general, the group is also able to identify and resolve plan-specific problems when they occur.**

**In addition to these activities, the State monitors coordination of care between plans and providers through direct participation in the Regional Advisory Committee (RAC) which provides a forum for the resolution of coordination-**

**related issues and through regular monitoring of complaints to track any trend or pattern that indicates problems with the coordination of care.**

**Furthermore, on a monthly basis the Local Behavioral Health Authority (LBHA) reports to the State any problems related to access or to the coordination of care that has been identified on the local level.**

**c.**_X_ [Required for all elements checked in the previous waiver submittal if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe the State's efforts during the previous waiver period to ensure that primary care providers in FFS, PCCM or MCO programs and PIHP/PAHP providers were educated about how to detect MH/SA problems for both children and adults and where to refer clients once the problems were identified. Please describe the requirements for coordination between FFS, PCCM, or MCO providers and PIHP/PAHP providers. Please describe how this issue was addressed in the PIHP/PAHP program.

**The State has developed coordination guidelines that require STAR (physical health care) and NorthSTAR plans to:**

- **provide cross training to providers in both plans on how to recognize physical health and behavioral health problems.**

- **make educational opportunities available for PCPs and THSteps (children's physical health) providers to promote the appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.**

- **enter into an agreement with Medicaid STAR (physical health) plans in the service area to operationalize strategies necessary to ensure coordination of care for consumers served by both plans including, but not limited to, methods of assuring that providers understand and demonstrate competency in referral strategies between the two plans, that provider education is implemented in multiple formats, including printed materials and forums, to promote knowledge among providers in both plans that will be useful in assisting enrollees with understanding benefits, access to care, and access to necessary ER services.**

- **participate on a Regional Advisory Committee (RAC) established in the service area that is designed to identify and address any systemic coordination issues related to managed care.**

**Beginning in the first year that NorthSTAR was operational, the BHOs have participated in the regular monthly meetings of the clinical coordination groups with STAR plan providers to establish coordination mechanisms and to address coordination and treatment related issues and in the quarterly**

**RAC meetings. When requested, the BHOs have also attended the Local Behavioral Health Authority board meetings (and other community based meetings) to both receive input and to provide information to the LBHA and other community organizations. The single BHO has continued its participation in all the above activities.**

d._X_ [Required if this is a PIHP/PAHP mental health, substance abuse, or developmentally disabled population waiver] Please describe how pharmacy services prescribed to program enrollees were monitored in this waiver program.

**Pharmacy services for Medicaid eligible individuals are not provided through this program. NorthSTAR enrollees may access prescription medications through the Texas Medicaid Vendor Drug Program**

**Upcoming Waiver Period** -- Please describe how standards for continuity and coordination of care will be monitored in the upcoming two year period.

**a.** How often and through what means does the State monitor the coordination and continuity standards checked above in Item B.V?

**The State will continue to:**

- **Provide the leadership to ensure that the STAR/NorthSTAR programs continue to improve care coordination through policy and operations (The State meets with the care manager group at least quarterly)**
- **Ensure the continuation of focused QI initiatives that develop intervention to improve the care coordination between the STAR and NorthSTAR programs (The State meets at least quarterly with the care manager group and bi-monthly by the BHO Quality Management Committee)**
- **Participate in meetings of the Regional Advisory Committee (RAC) to identify and address coordination-related issues (The State participates in quarterly meetings)**
- **Track complaint trends or patterns to identify and correct problems related to continuity of care (The State tracks complaint trends from monthly reports submitted by the BHO and the LBHA)**
- **Receive and review reports from the LBHA in which any local issues related to care coordination may be identified (The State reviews monthly reports submitted by the LBHA)**
- **Meet with the policy coordination group to address identified ongoing issues related to coordination of care. (The State meets with the care manager group at least quarterly)**

**b.** Specify below which providers are excluded from the capitated waiver and how the State explicitly requires the MCO/PIHP/PAHP to coordinate health care services with them:

1.___ Mental Health Providers (please describe how the State ensures coordination exists):
**NorthSTAR incorporates mental health providers into the program.**

2.___ Substance Abuse Providers (please describe how the State ensures coordination exists):
**NorthSTAR incorporates mental health providers into the program.**

3.___ Local Health Departments (please describe how the State ensures coordination exists):

4.___ Dental Providers (please describe how the State ensures coordination exists):

5.___ Transportation Providers (please describe how the State ensures coordination exists):

6.___ HCBS (1915c) Service (please describe how the State ensures coordination exists):

7.___ Developmental Disabilities (please describe how the State ensures coordination exists):

8.___ Title V Providers (please describe how the State ensures coordination exists):

9.___ Women, Infants and Children (WIC) program

10.__ Indian Health Services providers

11.__ FQHCs and RHCs not included in the program's networks

12._X_Other (please describe):
**Health and Human Services Commission STAR program:**

**As a Behavioral Health carve-out, NorthSTAR focuses coordination activities on STAR (the primary source of referrals to NorthSTAR program). Formal coordination mechanisms have been established with STAR to help assure that policies and protocols are in place to address care coordination issues.**

**Section C. QUALITY OF CARE AND SERVICES**

A Section 1915(b) Waiver program may not substantially impair enrollee access to medically necessary services of adequate quality. In addition, MCOs, PIHPs, and PAHPs must meet certain statutory or regulatory requirements addressing quality of health care. This section of the waiver submittal will document how the State has monitored and plans to meet these requirements.

**I. Elements of State Quality Strategies: --** This section provides the State the opportunity to describe the specifications it has implemented to ensure the delivery of quality services. To the extent appropriate, the specifications address quality considerations and activities for special needs populations.

**Previous Waiver Period**

**a.**_X_ Summarize the results of or include as an attachment reports from the External Quality Review Organization, results from performance improvement projects, and other monitoring reports from the previous waiver period. Describe any follow-up done/planned to address study findings [item C.I.c in 1999 initial preprint; item B.2 in 1995 preprint, item C.1 Upcoming Waiver Period, 1999 Waver Renewal Preprint].

**Attached to this document are the following reports and study results/proposals:**

- **Results of State BHO On-Site Review (April 2002)-Attachment #1**
- **FY 03 EQRO Quarterly Reports (First and Second Quarters)-Attachment #2**
- **Chemical Dependency Focus Study proposal submitted by EQRO-Attachment #3**
- **Care Coordination Focus Study proposal submitted by EQRO-Attachment #4**
- **BHO Follow-Up to ADHD Focus Study-Attachment #5**
- **BHO Follow-Up to Pregnancy and Substance Abuse Focus Study-Attachment #6**
- **BHO Study "Improving Access to the Clinical Referral Line"-Attachment #7**
- **BHO Study "Improving Ambulatory Follow-Up Care within 7 Days after Hospitalization for Mental Illness-Attachment #8**

**Follow-up studies were done for the ADHD and Pregnancy and Substance Abuse Focus Studies that were completed during the initial waiver cycle. The BHO will be conducting a follow-up study for their Focus Study on Improving Ambulatory Follow-Up Care during the upcoming waiver cycle. It is also anticipated that follow-up studies will be done subsequent to completion of the two EQRO Focus Studies. Additionally, the State plans to conduct another BHO on-site review during the upcoming waiver cycle.**

**b.__** Intermediate sanctions were imposed during the previous waiver period. Please describe.

**Upcoming Waiver Period --** Please check any of the items below that the State requires.

**a._X_**[Required] The State has a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. Please indicate if the strategy has already been submitted to CMS. If not, please attach a copy (Attachment C.1.a).

**Attached is a copy the TDMHMR/TCADA Quality Monitoring Strategies For NorthSTAR Managed Behavioral Healthcare-Attachment #9.**

**b._X_**[Required] The State must obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final.

**c._X_**[Required] The State must conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy as needed.

**d.**_X_ [Required] The State must arrange for an annual, independent, external review of the quality outcomes and timeliness of, and access to the services delivered under each MCO and PIHP contract. Note: EQR for PIHPs is required beginning 8/14/03.

1. Please specify the name of the entity:
   **Institute for Child Health Policy (ICHP)**

2. The entity type is:
   (a)__ A Peer Review Organization (PRO).
   (b)__ A private accreditation organization approved by CMS.
   (c)_X_A PRO-like entity approved by CMS.

3. Please describe the scope of work for the External Quality Review Organization (EQRO):
   **The State has contracted with the EQRO to perform the following activities in the scope of their work:**
   - **Evaluate MCO/BHO quality improvement plans**
   - **Calculate performance measures and outcomes**
   - **Assume responsibility for the Utilization Data Transfer (UDT)**
   - **Conduct annual medical record reviews**
   - **Submit required quarterly and annual reports (Ad Hoc reports if necessary)**
   - **Design 2 focus studies, results of which to be submitted to the State within 12 months of the contract award.**
   - **Design a process for certifying the quality of encounter data**

**e.**_X_ The State includes required internal quality assessment and performance improvement (QAPI) standards in its contracts with MCOs and PIHPs.

**f.**_X_ The State monitors, on a continuous basis, MCO/PIHP adherence to the State standards, through the following mechanisms (check all that apply):

1._X_ Reviews and approves each MCO's/PIHP's written QAPI. Such review shall take place prior to the State's execution of the contract with the MCO/PIHP.
2._X_ [Required] Reviews the impact and effectiveness of each MCO's/PIHP's written QAPI at least annually.

3._X_ Conducts monitoring activities using (check all that apply):

   (a)__ State Medicaid agency personnel

   (b)_X_Other State government personnel (please specify):
   **Staff from the Texas Department of Mental Health and Mental Retardation (NorthSTAR QI Staff) and the Texas Commission on Alcohol and Drug Abuse (NorthSTAR Contract Manager).**

   (c)__ A non-State agency contractor (please specify):

4.__ Other (please specify):

**g.**_X_ [Required] The State has established intermediate sanctions that it may impose.

**h.**_X_ [Required] The State has standards in the State QAPI, at least as stringent as those required in 42 CFR 438 Subpart D for access to care, structure and operations, and measurement and improvement .

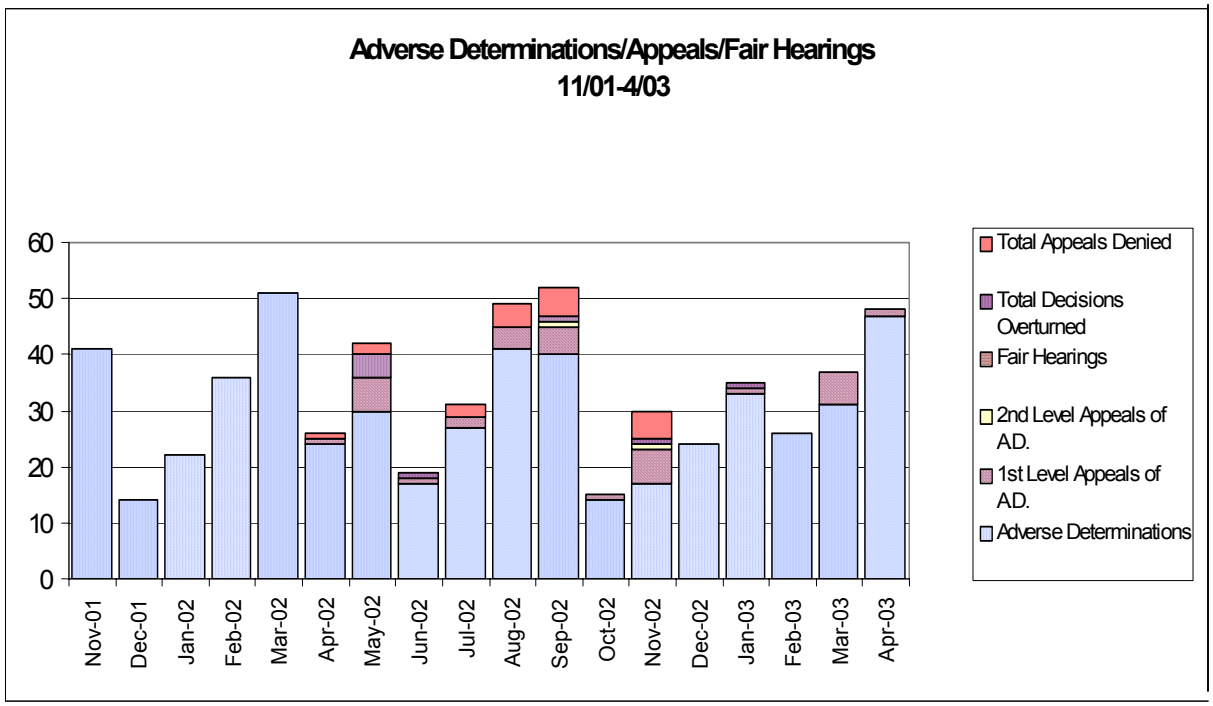
## II. Access Standards

### Coverage and Authorization of Services

**Previous Waiver Period**

**a._X_** [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of coverage and authorization of services for the previous waiver period, including a summary of any issues/trends identified in the areas of authorization of services and under/over utilization [items C.II.a-e in 1999 initial preprint; relevant sections of the 1995 preprint, item C.II Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

**The State requires the BHO to provide monthly reports of adverse determinations, appeals and denials overturned on appeal. Chart C.3. depicts this data for the period 11/01-4/03.**




**The State tracks this data to detect trends or patterns which may indicate that the BHO is inappropriately denying authorization. During the period 11/01 through 4/03, the State has detected that most of the adverse**

**determinations/appeals that have occurred have involved Supported Housing and Community Support Services (Rehabilitative Services). These are services in which the BHO has attempted to manage more closely, to ensure appropriate utilization. Only 6% of the total adverse determination for this period resulted in a provider appeal. Of the 6% appealed, 28% resulted in an overturned decision. Although all Medicaid enrollees are informed of their right to a Fair Hearing (in the enrollment materials and in correspondence from ValueOptions, the State has not received any requests for Medicaid Fair Hearings**

**Upcoming Waiver Period** -- Please check any of the following processes and procedures that the State requires to ensure that MCOs, PIHPs, and/or PAHPs meet coverage and authorization requirements.

Contracts with MCOs,PIHPs, and PAHPs:

**a.**_X_ [Required] Identify, define and specify the amount, duration and scope of each service offered, differentiating those services that may be available to special needs populations only, as appropriate. Note: These services may not be furnished in an amount, duration, and scope that is less than the amount, duration, and scope for the same services under the State Plan.

**While there are no specific mandates with regard to amount, duration or scope of services, NorthSTAR mandates the use of specialty providers for adults with severe mental illness (SMI) and children with severe emotional disturbance (SED) who have multiple or complex behavioral health needs. The BHO is required to subcontract with specialty providers to provide and coordinate necessary treatment for individuals in these populations who require multiple services. This approach:**

- **helps to assure that individuals with more severe behavioral health needs receive services from providers who are experienced in providing services to this special population;**
- **allows the close coordination of care for enrollees who need to receive services from multiple providers; and**
- **helps to minimize confusion and frustration of consumers who are required to seek services from a number of providers.**

**The BHO is given latitude to determine amount, duration and scope of services provided as long as such determination is in accordance with medical necessity.**

**b**._X_[Required] Require that the MCO, PIHP, or PAHP may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;

**c.**_X_ [Required] Include a definition of “medically necessary services”. This

definition can be no more restrictive than that used in the State Plan. Please list that specification or definition:

**Medically Necessary Service – A behavioral health service that:**

- **is reasonably necessary for the diagnosis or treatment of a mental health or chemical dependency disorder to improve or maintain an individual's level of functioning resulting from such a disorder;**
- **is in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;**
- **is furnished in the most appropriate and least restrictive setting in which services can be safely provided;**
- **is the most appropriate level or supply of service which can safely be provided; and**
- **could not be omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered.**

**d.**_X_ [Required] Include written policies and procedures for the processing of requests for initial and continuing authorizations of services.

**The BHO is contractually required to arrange for covered services within the following time periods**

- **Emergency behavioral health services - immediately (no prior authorization is required);**
- **Urgent Care: within 24 hours of request, including transfer between levels of care during a chemical dependency episode;**
- **Routine Care: within 14 calendar days of request;**
- **For telephone services and queries:**
  - **telephone callers reach a non-recorded voice within 30 seconds: and**
  - **telephone abandonment rates do not exceed 5 percent at any given time.**

**The State also requires the BHO to include in its enrollee complaint system expedited appeals concerning denials of continued stays for hospitalization.**

**e._X_**[Required] Require that the MCO, PIHP, and PAHP have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

**Under the State's definition of Medical Necessity, the BHO is obligated to provide services that are necessary for the diagnosis or treatment of a mental health or chemical dependency disorder to improve or maintain an individual's level of functioning resulting from such a disorder. The State has approved the BHO's utilization management criteria, policies, and procedures. On an ongoing basis, the State monitors that process directly from provider sites, or any complaints received through the complaint tracking system.**

**f.**_X_[Required] Require that the MCO,PIHP, and PAHP consult with the

requesting provider when appropriate.

**g._X_**[Required] Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

**h**._X_[Required] Require that, for standard authorization decisions, notice is provided as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days. The timeframe may be extended up to an additional 14 days if the enrollee or provider requests an extension or if the MCO, PIHP, and PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

**i**._X_ [Required] Require that the MCO,PIHP, or PIHP make an expedited authorization decision no later than 3 working days after receipt of the request for service. The timeframe may be extended up to 14 days if the enrollee requests an extension or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest.

**j.___** Other (please describe):

## III. Structure and Operation Standards

### Provider Selection

### Previous Waiver Period

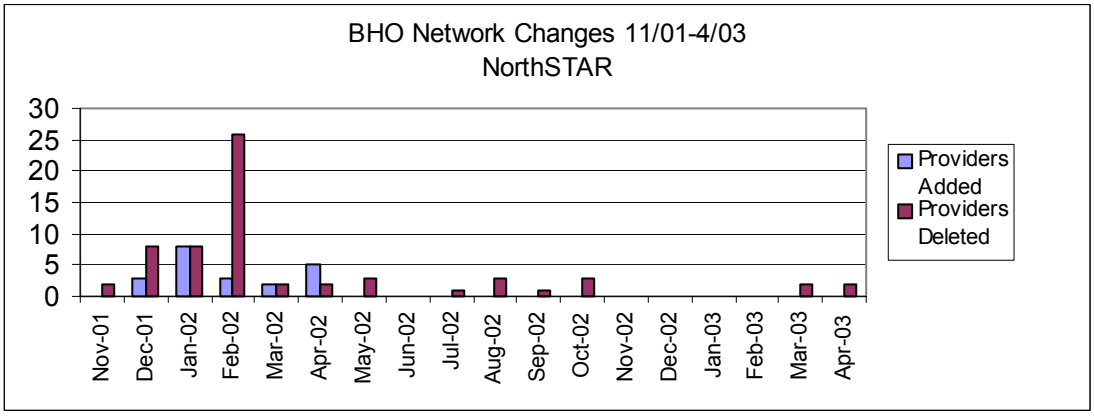
[Required for all related items checked in previous waiver request] Please provide results from the State's monitoring efforts for compliance in the area of selection and retention of providers for the previous waiver period. **The State receives monthly network change reports from the BHO that identify the providers that have joined or departed from its network. The State uses this data to assess rates of provider recruitment, retention and loss that affect the BHO network.**

**The EQRO also reviews the credentialing process during scheduled on-site reviews. The State utilizes information from these reviews to determine if the BHO is complying with the State's mandatory credentialing requirements.**

**The State's monitoring of BHO provider selection and retention indicates that it has been effective in recruiting and retaining providers. Nevertheless, there have been providers who have ceased participation in the project. The primary reason for these providers' non-participation was non-renewal of their BHO**

**contracts (some cited rates of payment and/or paperwork requirements). Most of these departing providers were masters-level clinicians (LPCs, LMSW-ACPs). The BHO network has many providers of these disciplines in their network.**

**The Following Table Depicts the Network Changes for the previous 11/03 through 4/03**




**Upcoming Waiver Period**

The State must establish a uniform credentialing and recredentialing policy that each MCO, PIHP, and PAHP must follow. Please check any of the following processes or procedures that the State includes in its policy

**a.**_X_ [Required] Each MCO, PIHP, PAHP must develop and implement a documented process for selection and retention of providers.

**b**. _X_[Required] Each MCO, PIHP, PAHP must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment solely on the basis of the population served or condition treated.

**c.**_X_Each MCO, PIHP, PAHP must have an initial credentialing process for physicians and other licensed health care professionals including members of physician groups that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

**d.**_X_ Each MCO, PIHP, PAHP must have a recredentialing process for physicians and other licensed health care professionals including members of physician groups that is accomplished within the time frames set by the State, and through a process that updates information obtained through the following (check all that apply):

1._X_ Initial credentialing

2._X_ Performance indicators, including those obtained through the following (check all that apply):

(a)_X_The quality assessment and performance improvement program
(b)_X_The utilization management system

(c)_X_The grievance system

(d)_X_Enrollee satisfaction surveys

(e)__ Other MCO/PIHP/PAHP activities as specified by the State.

**e.**_X_ Determine, and redetermine at specified intervals, appropriate licensing/ accreditation for each institutional provider or supplier. Please describe any licensing/accreditation intervals required by the State
**The BHO is contractually obligated to re-credential providers at least every two years.**

**f.**_X_ Have an initial and recredentialing process for providers other than individual practitioners (e.g., home health agencies) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
**The BHO is required to identify those providers who fall under its scope of authority and action. This includes, at a minimum, all providers of client care, whose service to enrollees is contracted or anticipated, regardless of licensure status.**

**g.**_X_ Notify licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of providers take place because of quality deficiencies.
**The BHO is required to have a mechanism for, and evidence of implementation of, the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.**

**h.___** Other (please describe):

## IV. Subcontractual Relationships and Delegation

**Previous Waiver Period**

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of

delegation for the previous waiver period [items C.IV.a-i in 1999 initial preprint; relevant sections of the 1995 preprint, item C.IV Upcoming Waiver period, 1999 Waiver Renewal Preprint].

**The State has reviewed and approved all model contracts in use by the BHO and reviews any contract or amendment that substantially departs from the model. The State has also monitored provider complaints to identify any trends or patterns related to contractual/delegation issues. The State has not identified any issues, which indicate a need to alter the BHO subcontracting/delegation processes and procedures currently in place.**

**Upcoming Waiver Period**

Please check any of the processes and procedures from the following list that the State uses to ensure that contracting MCOs, PIHPs, and PAHPs oversee and are accountable for any delegated functions.

Where any functions are delegated by MCOs, PIHPs, or PAHPs, the State Medicaid Agency:

**a._X_** Reviews and approves (check all that apply):

1.___ All subcontracts with individual providers or groups

2._X_ All model subcontracts and addendum

3.___ All subcontracted reimbursement rates

**The State requires the contract to specify the method by which the provider will be reimbursed and at what rate for services performed. The State does not require the BHO to disclose rates paid to other subcontracted providers for the same service(s).**

4.___ Other (please describe):

**b.**_X_ [Required] Monitors to ensure that MCOs,PIHPs, and PAHPs have evaluated the entity's ability to perform the delegated activities prior to delegation.

**c.**_X_ [Required] Requires agreements to be in writing and to specify the delegated activities.

**d.**_X_ [Required] Requires agreements to specify reporting requirements.

**e.**_X_ [Required] Requires written agreements to provide for revocation of the delegation or other remedies for inadequate performance.

**f.**_X_ [Required] Ensures that MCOs,PIHPs, and PAHPs monitor the

performance of the entity on an ongoing basis.

**g.**_X_ [Required] Monitors to ensures that MCOs,PIHPs, and PAHPs formally review the entity's performance according to a periodic schedule established by the State.

**h.**_X_[Required] Ensures that MCOs,PIHPs, and PAHPs retain the right to approve, suspend or terminate any provider when they delegate selection of providers to another entity.

**i.**_X_ [Required] Requires MCOs,PIHPs, and PAHPs to take corrective action if any deficiencies or areas for improvement are identified.

**j.___** Other (please explain):

## V. Measurement and Improvement Standards

### Practice Guidelines

### Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of practice guidelines for the previous waiver period [items C.V.a-h in 1999 initial preprint; relevant sections of the 1995 preprint].

**To date the State has not adopted disease-specific practice guidelines for behavioral health disorders. The State has adopted several "best practices" that are included in NorthSTAR. These best practices include, but are not limited to:**

**(1) The use of a Specialty Provider Network (SPN) for:**

- **any person who was discharged from a State psychiatric hospital with an indicated need for specialty wrap-around services or who can not be served adequately without multiple services; or**
- **any person who at the time of intake or assessment is determined by a BHO credentialed provider to be in need of multiple specialty wrap-around services.**

**(2) Assertive Community Treatment (ACT) services for:**

**individuals who have severe symptoms and impairments that are not effectively remedied by available treatments or who, for reasons related to their mental illness, resist or avoid involvement with mental health services.**

**Monitoring by the State indicates that SPN services are readily available to individuals who may need such services. Additionally, ACT services are also more widely available under NorthSTAR than were available under the traditional fee-for-service system - with 3 additional providers of ACT entering**

**the BHO network during the first 22 months of program operation**

**(3) Evidence-based practices to include:**

- **family education and support services**
- **integrated dual diagnosis assessment and treatment**
- **supported employment**
- **targeted case management (i.e., service coordination)**
- **wrap-around services for children**

**In addition to these best practices, the BHO is required to submit for the State's approval the BHO's clinical criteria for placing enrollees in State hospitals and in community-based hospitals. The State also monitors service utilization and complaint data to identify problems related to service authorization and access. The State has directly monitored authorization processes and protocols through on-site visits at a variety of provider service delivery sites. These monitoring activities have not resulted in any significant findings of non-compliance on the part of the BHO.**

**In accordance with the pending BBA regulations, the State will contractually require the BHO to adopt practice guidelines where such guidelines exist that are based on valid and reliable clinical evidence or a consensus of health care professionals in the field of behavioral health care. The State will mandate that these guidelines consider the needs of enrollees and are adopted in consultation with contracting health care professionals and are reviewed and updated periodically as appropriate.**

**Upcoming Waiver Period -** Please check any of the processes and procedures from the following list that the State requires to ensure that MCOs, PIHPs, and PAHPs adopt and disseminate practice guidelines.

**a.**_X_ [Required] Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.

**b.**_X_ [Required] Guidelines consider the needs of the MCO's, PIHP's or PAHP's enrollees.

**c.**_X_ [Required] Guidelines are developed in consultation with contracting health professionals.

**d.**_X_ [Required] Guidelines are reviewed and updated periodically.

**e.**___ [Required] Guidelines are disseminated to all affected providers, and, upon request to enrollees and potential enrollees.

**f.**_X_ [Required] Guidelines are applied in decisions with respect to utilization

management, enrollee education, coverage of services, and other relevant areas.

**g.___** Other (please explain):

**Quality Assessment and Performance Improvement (QAPI)**

**Previous Waiver Period**

a._X_ [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts to determine the level of compliance in the area of QAPI for the previous waiver period [items C.VII.a-u in 1999 initial preprint; relevant sections in the 1995 preprint, item C.VII Upcoming Waiver Period, 1999 Waiver Renewal Preprint]. Please break down monitoring results by subpopulations if available.

**The State has dedicated one full time equivalent position (FTE) to monitor the NorthSTAR BHO's implementation of the QAPI plan. This position is responsible for reviewing and approving the BHO's plan, participating in the BHO's Quality Improvement Committee meetings, identifying problems and ensuring follow through on identified issues. Additionally, this position is responsible for gathering information from outside resources – such the Local Behavioral Health Authority, STAR program providers, medical care advisory committees and the NorthSTAR contract manager in order to identify and address issues that arise outside of the BHO's quality improvement plan. Specific problem identified and addressed to date include issues related to:**

- **discharge planning**
- **facilitating effective working relationships between hospitals and the BHO**
- **hospital utilization patterns**
- **follow through with services following a hospital discharge**
- **provider issues related to hospital admissions**
- **coordination of care issues**

**Work is ongoing to examine and address re-hospitalization rates and to further improve coordination of care.**

**NorthSTAR is a carve-out and as such serves a specific sub-population (i.e., individuals with behavioral healthcare needs). During the initial waiver cycle NorthSTAR completed two focused studies directed at children with ADHD and pregnant women who are chemically dependent. Follow-up studies on both these topics were done during the –previous waiver period. The BHO also completed two new studies during the previous waiver period. The first study focused on improving ambulatory follow-up care within 7 days after**

**hospitalization for mental illness, and the second study addressed improving access to the clinical referral line.**

**Additionally, focus studies are currently proposed by the EQRO to address care coordination for children, and length of stay, transitions, and clinical outcomes of chemical dependency treatment. Further monitoring in the area of QAPI was accomplished when the State conducted an on-site review of the BHO in April 2002. The State has also contracted with The LBJ School at the University of Texas at Austin to do an external evaluation of the program. The evaluation is scheduled for completion in summer 2003. (Refer to the next question for additional information)**

b._X_ The State or its MCOs and PIHPs conducted performance improvement projects that achieve, through on-going measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Please list and submit findings from the projects completed in the previous two year period.

**The studies completed in the previous waiver cycle are attached to this document and are summarized below:**

**1. Follow-Up: Attention Deficit/Hyperactivity Disorder in Children and Communication with Patient's Primary Care Physician (Attachment #5)**

**This study was a follow-up to a baseline study that was done in the initial waiver cycle indicating behavioral health and physical health services providers were not communicating consistently. The State and the BHO determined that increasing the coordination of care in children with ADHD was deemed to be the priority improvement initiative. The findings of the follow-up study indicated a significant increase in evidence of care coordination and communication between behavioral and physical health care providers (20% evidence of coordination in the baseline study and 68% in the follow-up study).**

**2. Follow-Up: NorthSTAR Pregnancy/Substance Abuse (Attachment #6)**

**This study followed up on the results of a study conducted in the initial waiver period that focused on the coordination of behavioral health and physical health care services for women who were pregnant or of childbearing age . The follow-up study indicated that, in approximately 25% of the clinical case notes reviewed, coordination of care was not possible because the member's HMO could not be identified. When these cases were removed from the sample, 81% of clinical case notes indicated evidence of coordination of behavioral and physical health care. This represents a significant increase over baseline**

**findings (58% of the baseline cases showed evidence of coordination).**

**3. New Study: Improving Ambulatory Follow-Up Care within 7 Days after Hospitalization for Mental Illness (Attachment #8)**

**Health plan members who are hospitalized with a mental health diagnosis are a high-risk population. They are an inherently vulnerable population that requires frequent monitoring. The BHO recognizes this need for frequent monitoring of recently discharged members and has implemented this measure as a quality indicator in an effort to reduce clinical symptoms and improve quality of life.**

**The nationally standardized HEDIS method of calculating ambulatory follow-up was adapted and used in two measurement periods, a 12-month baseline period and a subsequent 12-month remeasurement period. During the baseline period, the rate of follow-up within 7 days of discharge was 37.33%. During the remeasurement period, the percent of members having follow-up within 7 days post-discharge was 33.01%. In both cases, these findings fell short of the goal of 51% compliance. The findings of this study indicate that there is opportunity for improvement in 7-day ambulatory follow-up. The BHO will do a follow-up of this study during the upcoming waiver period.**

**4. New Study: Improving Access to the Clinical Referral Line(Attachment #7)**

**The philosophy of the BHO is to operate a care management system that strives to offer easy and immediate access to the most appropriate quality mental health and substance abuse services for members. The ability for persons in need to access clinical care managers through the ACCESS LINE is critical to achieving this goal. Phone statistics, including average speed of answer and abandonment rates, are accepted industry access indicators. After a 6-month baseline analysis, the BHO identified the need for improvement in this area. The benchmarks of an average speed of answer 30 seconds or less, and an abandonment rate of 3 % or less were not being met (NorthSTAR permits an abandonment rate of up to 5%, but the BHO adheres to their corporate policy of 3% or less). As a result, team building and administrative corrective interventions were implemented. Remeasurements were then done monthly for the next six months. Quantitative analysis of these remeasurements indicated that the interventions made a positive impact on performance. When comparing the first six month period (baseline) to the subsequent six month remeasurement period, there was an improvement of 60% to the average speed of answer, and the goal of a less than 30 second answer rate was attained. Similarly, the abandonment rate improved by 300% over the baseline measurement, and the goal of less than 3% abandonment rate was also attained. No follow-up for this performance indicator is planned at this time due to the**

**successful findings of the study. Instead, other performance areas will be examined to identify those in need of improvement for further study.**

**Upcoming Waiver Period**- The State must require that each MCO and PIHP have an ongoing QAPI for the services it furnishes to its enrollees.

**a**._X_[Required] The State must review, at least annually, the impact and effectiveness of each MCO's and PIHP's QAPI. This review includes:

1._X_ The MCO's and PIHP's performance on the standard measures on which it is required to report.

2._X_ The results of each MCO's and PIHP's performance improvement projects.

**b**. _X_Please check any of the following processes and procedures that the State includes as a requirement for MCO and PIHP QAPIs

Each MCO and PIHP must have:

1._X_ A policy making body which oversees the QAPI

2._X_ A designated senior official responsible for program administration and documentation of Quality Improvement committee activities.

3._X_ Active participation by providers and consumers

4._X_ Ongoing communication and collaboration among the Quality Improvement policy making body and other functional areas of the organization.

5.___ Other (please describe):

**c._X_**[Required] Each MCO and PIHP must have in effect mechanisms to detect both underutilization and overutilization of services. Please describe these mechanisms:

**The BHO has a Utilization Management Committee is responsible for developing and monitoring indicators to detect under and over-utilization of services. The committee is comprised of the medical director, clinical director, quality management director, and clinical supervisors. Processes monitored to accomplish this task are as follows:**

- **Auditing**
- **No Shows**
- **Discrepancies in request vs. authorization and percentage of reconsideration**
- **Denials**

- **Increased frequency of scheduled visits for no shows**
- **Complaints**
- **Positive Urine Drug Screens**
- **Crisis system utilization**
- **Against Medical Advice (AMA) discharge**
- **Daily staffing for intensive utilization cases**
- **Review of disenrollment report**
- **Review of timely access to evaluation**
- **Medical records**
- **Intensive review of discharge planning**
- **Requests vs. authorizations and percentage to appeal**
- **Notifications of team and signoff**
- **Intensive review of top 5% Crisis Users**
- **Pharmacy utilization**
- **Number of encounters**
- **Monthly reporting**

**d**. _X_[Required] Each MCO and PIHP must have in effect mechanisms to assess the quality and appropriateness of care furnished to **enrollees with special health care needs.** Please describe these mechanisms:

**While not included within an official State definition, NorthSTAR serves individuals with mental illness and/or chemical dependency. As a behavioral health specialty "carve out", NorthSTAR has as its primary focus the delivery of specialized services to this population.**

**The BHO has requisite standards for network providers who provide services for enrollees with special health care needs. Providers are required to:**

- **Develop a treatment plan and ensure service coordination for each enrollee for whom the provider is responsible**
- **Assess persons referred by the courts for involuntary mental health commitments and provide service coordination to ensure appropriate coordination of treatment**
- **Provide specialized mental health services for adults with SMI**
- **Provide specialty mental health services to children with SED**
- **Be responsible for activities under the federal PATH grant for outreach to homeless persons with mental illness (in Dallas County only)**
- **Provide outreach to persons with mental illness in local jails and juvenile facilities**
- **Provide information and data as required to the BHO to track services and treatment outcomes**

**In addition, the State has a definition of children with special needs that includes children who are**

- **Blind/disabled children and related populations (eligible for SSI under Title XVI)**

- **Eligible under Section 1902(e)(3) of the Social Security Act**
- **In foster care or other out-of-home placement**
- **Receiving adoption assistance**
- **Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as is defined by the State in terms of either program participant or special health care needs**

**While the State definition of Children with Special Needs includes the categories indicated above, NorthSTAR only serves children in <u>two</u> of these categories – Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI) and children receiving adoption assistance. Children in these two categories are specifically identified by Medicaid program and type in the State's enrollment system.**

**e.**_X_[Required] Each MCO and PIHP must measure and report to the State its performance, using standard measures required by the State. Please list or attach the standard measures currently required.

**Mental Health Performance Measures**

| **Performance Measure** | **Data Collection** |
|---|---|
| Percent of Parents reporting satisfaction with their children's care | Consumer Survey |
| Percent of children receiving MH community services whose school performance improved | BHO - Client Data Elements |
| Percent of children and adolescents receiving MH community services with a history of arrest who avoid re-arrest | BHO - Client Data Elements |
| Percent of Adults reporting quick and easy access to service | Consumer survey |
| Percent of Adults who are satisfied with MH services received | Consumer survey |
| Percent of adults reporting positive outcomes of treatment | Consumer Survey |
| Improvement in housing | BHO - Client Data Elements |
| Improvement in employment | BHO - Client Data Elements |
| Inpatient Utilization for SPN clients | BHO - Client Data Elements |
| Percent of adults with reduced symptoms | BPRS (SPN) |

**<u>Chemical Dependency Performance Measures</u>**

| Performance Measure | **Data Collection** |
|---|---|
| Percent of youth completing treatment programs who report they are abstinent when contacted following discharge | BHO - Client Data Elements |
| Percent of adults completing treatment programs who report they are abstinent when contacted following discharge | BHO - Client Data Elements |
| Percent of unemployed adults completing treatment programs who report they are employed when contacted following discharge | BHO - Client Data Elements |
| Percent of youth completing treatment programs who report they are not rearrested when contacted following discharge | BHO - Client Data Elements |
| Percent of adults completing treatment programs | BHO - Client Data Elements |
| Percent of youth completing treatment programs | BHO - Client Data Elements |

**The State is reporting BHO performance measures using our own data and reports.**

**Performance Improvement Projects**

**f.**_X_ [Required] Each MCO and PIHP must conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
**Performance Improvement Projects planned for the upcoming waiver cycle are attached to this document.**

**g.**_X_ Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

**h.**_X_[Required] Each MCO and PIHP must report the status and results of each project to the State as requested.

Please list or attach the projects currently planned for each year of the waiver period either at a state or plan-level. Please describe the types of issues that are included in clinical (e.g., acute/chronic conditions, high-volume/high-risk services) and non-clinical (e.g., complaints, appeals, cultural competence, accessibility) focus areas as defined by the State.
**Attached to this document are the two EQRO focus studies planned for the upcoming waiver period. The Care Coordination for Children study addresses**

**the QISMC Domain 1 §1.3.4 clinical focus area of Continuity and Coordination of Care. The study entitled Profiles and Predictors of Length of Stay, Transitions between Levels of Care, and Clinical Outcomes of Chemical Dependency addresses the Domain 1 QISMC clinical focus areas of §1.3.4.3 Care of Acute Conditions, and §1.3.4.4 Care of Chronic Conditions.**

**The results of the BHO study on Improving Ambulatory Follow-Up Care within 7 Days after Hospitalization for Mental Illness indicated there is still a need for improvement for this performance indicator. Therefore, a follow-up study will be conducted which will address the Domain 1 QISMC non-clinical focus area of §1.3.5.1 Availability and Accessibility of Services. Since the Access to the Clinical Referral Line study by the BHO showed performance indicators to be at or above the benchmarks, no follow-up is planned at this time. Instead, other areas for study will be identified.**

**i.**_X_ [Required] Each MCO and PIHP must measure performance using objective quality indicators.

**j**. _X_[Required] Each MCO and PIHP must implement system interventions to achieve improvement in quality.

**k.**_X_ [Required] Each MCO and PIHP must formally evaluate the effectiveness of the interventions.

**l**.__X__Each MCO and PIHP must correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

**m.**_X_MCOs or PIHPs are allowed to collaborate with one another on projects, subject to the approval of the State Medicaid agency.

**n.**_X_ Each MCO and PIHP must select topics for projects through continuous data collection and analysis by the organization of comprehensive aspects of patient care and member services.

**o.**_X_ Each MCO and PIHP must select topics in a way that takes into account the prevalence of a condition among, or need for a specific service by, the organization's enrollees; enrollee demographic characteristics and health risks; and the interest of consumers in the aspect of care or services to be addressed.

**p.**_X_ Each MCO and PIHP must provide opportunities for enrollees to participate in the selection of project topics and the formulation of project goals.

**q.**_X_ Each MCO and PIHP must establish a baseline measure of performance on each indicator, measure changes in performance, and continue measurement of at least one year after a desired level of performance is achieved.

**r.**_X_ Each MCO and PIHP must use a sampling methodology that ensures that results are accurate and reflective of the MCO's or PIHP's enrolled Medicaid population.

**s.**_X_ Each MCO and PIHP must use benchmarks levels of performance which are either determined in advance by the State Medicaid agency or by the organization.

**t.**_X_ Each MCO and PIHP must ensure that improvement is reasonably attributable to interventions undertaken by the organization (has face validity).

**u.___** Other (please describe):

## VI. Health Information Systems

### Previous Waiver Period

[Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts for compliance in the area of health information systems for the previous waiver period [items C.VI.a-i in 1999 initial preprint; relevant sections of the 1995 preprint].

**The State both monitors and provides guidance to the BHO in the development, implementation, and ongoing refinement of their information systems. As system functionality has expanded, the State works closely with the BHO to develop and apply business rules resulting in edits on data to ensure that it is compliant with State data reporting needs. The State also analyzes data provided by the BHO and works directly with the BHO to improve the quality of data by providing technical assistance to the BHO in order to assure that data flows efficiently between the BHO and the State. The intent is to have high consistency from the consumer case record through to the data warehouse.**

### Upcoming Waiver Period

Please check any of the processes and procedures from the following list that the State requires to ensure that contracting MCOs and PIHPs maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of the Medicaid Program.

The State requires that MCO and PIHP systems:

**a.**_X_ [Required] Provide information on
1._X_ Utilization,
2._X_ Grievances and appeals,
3._X_ Disenrollment for reasons other than loss of Medicaid eligibility.

**b.**_X_ [Required] Collect data on enrollee and provider characteristics as specified by the State.

**c.**_X_ Collect data on services furnished to enrollees through an encounter data system or such other methods approved by the State (please describe). The MCO/PIHP is capable of (please check all that apply):

1._X_ [Required] Recording sufficient patient data to identify the provider who delivered services to Medicaid enrollees

2._X_ [Required]Verifying whether services reimbursed by Medicaid were actually furnished to enrollees by providers and subcontractors

3._X_ [Required] Verifying the accuracy and timeliness of data

4._X_ [Required] Screening data for completeness, logic and consistency

5._X_ [Required] Collecting service information in standardized formats to the extent feasible and appropriate

6.___ Other (please describe):

**d.**_X_ Provide periodic numeric data and/or narrative reports describing clinical and related information for the Medicaid enrolled population in the following areas (check all that apply):

1._X_ Health services (please specify frequency and provide a description of the data and/or content of the reports)
**The BHO is required to ensure that a behavioral health assessment and treatment plan is completed within three days of a routine outpatient visit and within 48 hours of an emergency or urgent inpatient or residential placement. The State requires specific elements of assessment data to be submitted in extract form to the State on weekly basis.**

2.___ Outcomes of health care (please specify frequency and provide a description of the data and/or content of the reports)

3._X_ Encounter Data (please specify frequency and provide a description of the data and/or content of the reports)
**The BHO provides weekly data submissions to the State that includes in excess of 30 discrete data fields. Data included in these reports includes,**

**but is not limited to, enrollee identification, primary diagnosis, secondary diagnosis, tertiary diagnosis, provider identification, services provided and claim number, units allowed, units billed, paid amount, place of service, service begin date, service end date, and date of payment.**

4._X_ Other (please describe and please specify frequency and provide a description of the data and/or content of the reports)
**The BHO also provides additional data to the State in the form of reports on a monthly, quarterly or ad-hoc basis. Some of these reports include: enrollee complaint reports, adverse determinations and appeals, telephone response measurements, telephone abandonment rates, provider network change reports, provider complaints and appeal reports, third party recovery reports, complaint summary reports, quality assurance and improvement reports, behavioral health financial and statistical reports and HMO financial statements.**

**e.**_X_ Maintain health information systems sufficient to support initial and ongoing operation, and that collect, integrate, analyze and report data necessary to implement its QAPI.

**f.**_X__Ensure that information and data received from providers are accurate, timely and complete.

**g.**_X_ Allow the State agency to monitor the performance of MCOs/PIHPs using systematic, ongoing collection and analysis of valid and reliable data.

**h.**_X_ Ensure that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the organization that take into account professional standards.
**The BHO and all subcontractors are required to comply with either State established medical records standards set forth in the contract or the treatment records standards contained in the current National Committee for Quality Assurance (NCQA) Standards for Managed Behavioral Health Care Organizations.**

**i.**_X__Please provide a description of the current status of the State's encounter data system, including timeliness of reporting, accuracy, completeness and usability of data provided to the State by MCOs/PIHPs.

**j.**_X__The State uses information collected from MCOs/PIHPs as a tool to monitor and evaluate MCOs/PIHPs (i.e. report cards). Please describe.
**The State maintains a "Data Book" that is based on encounter data extracted from the State's data warehouse, enrollment data, complaint data, and reported data from the BHO which is used catalog, monitor, track and evaluate the performance of the BHO. This data is made available to the public.**

**This data, as well as other data collected from the BHO, is used:**

- **in the quality assessment and improvement activities undertaken by the State**
- **in both of the focused studies as well as in provider satisfaction polling**
- **to examine authorization / utilization patterns and trends**
- **to compare service delivery patterns**

**In addition to encounter data, the state reviews multiple types of information submitted by the BHO. This includes but is not limited to claims payment data, hospital utilization data and information submitted in quarterly QI reports.**

**Additionally the state compiles and analyzes complaint data that is submitted through multiple sources. The State has used these data to review service delivery patterns of specific providers within the BHO network and to monitor the total number of services delivered to sub-populations of NorthSTAR enrollees.**

**The State also utilizes additional data such as information provided by the LBHA, various advisory committees, the EQRO, data from satisfaction surveys, and additional data provided by the BHO to evaluate BHO performance.**

**k.___** The State uses information collected from MCOs/PIHPs as a tool to educate beneficiaries on their options (i.e. comparison charts to be used by beneficiaries in the selection of MCOs/PHPs and/or providers). Please describe.

**l.___** Other (please describe):

## Section D. 1915(B) COST-EFFECTIVENESS PREPRINT AND INSTRUCTIONS

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. Instead, States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

The 1915(b) Cost-Effectiveness Preprint and Instructions are divided into 4 major sections:

- Section I. Definitions and Terminology
- Section II. General Principles of the Cost-Effectiveness Test
- Section III. Instructions for Appendices
- Section IV. State Completion Section

In addition there are seven Appendices:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

**States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint.** The Appendices included with the Preprint have been filled in with a completed actual example from the State of Nebraska. Each State should modify the spreadsheet to reflect their own program structure and replace the Nebraska information with its own data. *Note: the example is for illustrative purposes only. It does not reflect Nebraska's actual experience or program structure.*

In addition, technical assistance is available through each State's CMS Regional Office. Each Regional Office has a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests.

| **Actual Waiver Service Cost + Actual Waiver Administration Cost<= Projected Waiver Cost** |
|---|

## I. Definitions and Terminology

The following terms will be used throughout this document and are defined below:

**For Initial Waivers:**

Historical Period

- BY = Base Year

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

**For Conversion Waivers *(existing waivers which will "convert" from the former "with and without waiver" cost effectiveness test to the newcost effectiveness test described in these instructions)*:**

Historical Period for first time a State completes the new cost effectiveness test

- BY = Base Year – CMS prefers 7/1/2001 – 6/30/2002

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

**For Renewal Waivers:**

Retrospective Waiver Period

- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

**Form CMS-64:** *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program* (MBES - formerly known as the HCFA-64) submitted by States as an accounting statement under Title XIX and Title XXI of the Social Security Act. The *Form CMS 64* is completed according to the reporting instructions in the State Medicaid Manual, Section 2500. Additional technical assistance is available through each State's CMS Regional Office. Each Regional Office will have a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests. In general, CMS-64 data is recorded based on the date that a payment was made to a provider.

**Form CMS-64 Summary and CMS-64.9:**

The *Form CMS-64 Summary* is an accounting of all expenditures for Medical Assistance **services and administration** for both MAP (CMS-64.9) and ADM (CMS-64.10) under Medicaid Title XIX and Title XXI Medicaid Expansion Groups including waiver expenditures. The Summary Sheet is generated from all worksheets entered by the State in support of each line item (including prior period adjustments). The *CMS-64.9* reports current expenditures for Medical Assistance **services** under the non-waiver

programs.

**Form CMS-64.10:** The *Form CMS-64.10* is an accounting of **administrative** expenditures in Medicaid Title XIX for non-waiver programs.

**Form CMS-64.21U:** The *Form CMS-64.21U* is an accounting of **service and administrative** expenditures for the State Medicaid Expansion portion of the Children's Health Insurance Program (SCHIP) Title XXI. This form reports expenditures for children covered under 1905(U)(2) and (U)(3) of the Social Security Act.

**Form CMS-64 F:**
The *CMS-64 F Form* recaps all *CMS-64.21 Medicaid Expansion Forms* and Medicaid *CMS 64.9 Forms*. The *CMS-64 F Form* is summarized in the *CMS-64 Summary Form*. The *CMS-64 F* describes the source of the data on each line of the *CMS-64 Summary*. An example follows:
*CMS-64 Summary*, Line 6 MAP = $100
*CMS-64 F*, Line 6 MAP, *Form CMS-64.9* = $80
*CMS-64F*, Line 6 MAP, *Form CMS-64.21* = $20

**Form CMS-64.9 Waiver:** Same as the *Form CMS-64.9* except the *Form CMS-64.9 Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver program. The State will provide separate *CMS-64.9 Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.9 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.9 Waiver form* for expenditures that are not included on other *64.9 Waiver forms*. The *CMS-64.9 Waiver forms* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.9 Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.9 Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.9 Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.9 Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instruction section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the following Standard 1915(b) Waiver coding system:

- State Code: This will be the State's two-digit identifier (e.g., CA, FL, PA);
- Two digit waiver number;

- Followed by the two-digit waiver renewal number; and
- Followed by the two-digit consecutive waiver year.

Please work with your RO if you need guidance identifying this number. *Example: The Iowa Plan reporting for a waiver renewed on July 1, 2001 would use: IA07.R02.05. The Iowa Plan is Iowa's seventh waiver. It was renewed for the second time on July 1, 2001. If the first year of their waiver began July 1, 1997, the waiver year beginning July 1, 2001 would be 05.*

| | |
|---|---|
| State Code | IA |
| Two-digit waiver number | 07 |
| Two-digit waiver renewal number | 02 |
| Two-digit consecutive waiver year | 05 |

**Form CMS-64.9P Waiver:** Same as the *CMS-64.9 Waiver* except reporting a prior period adjustment.

**Form CMS-64.10 Waiver:** Same as the *Form CMS-64.10* except the *Form CMS-64.10 Waiver* reports Administration costs only for the population and services covered by the State's 1915(b) waiver program. The State will provide separate *CMS-64.10 Waiver forms* for each 1915(b) waiver program. The State must report administrative costs attributable to each waiver program on separate *CMS-64.10 Waiver forms*. Administrative costs that are applicable to more than one waiver program must be allocated to the respective *CMS-64.10 Waiver forms* based on a method approved by CMS (e.g., allocation based on caseload or Medical Assistance payments). Therefore, the *CMS-64.10 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If the State has specific questions regarding this requirement, please contact your State's RO. To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system. *Note: States should document their cost allocation methodology for administration costs between waivers in D.IV.G.*

**Form CMS-64.10P Waiver:** Same as the *CMS-64.10 Waiver* except reporting a prior period adjustment.

**Form CMS-64.21U Waiver:** Same as the *Form CMS-64.21U* except the *Form CMS-64.21U Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver programs. Cost Effectiveness requirements apply only to Medicaid Expansion SCHIP populations under 1905(U)(2) and (U)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(U)(2) and (U)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program. The State will provide separate *CMS-64.21U Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.21U Waiver forms* will contain data that is a subset of the data contained in the

*Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.21U Waiver form* for expenditures that are not included on other *64.21U Waiver forms*. The *CMS-64.21U Waiver sheets* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.21U Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.21U Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.21U Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.21U Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instructions section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system.

**Form CMS-64.21UP Waiver:** Same as the *CMS-64.21U Waiver* except reporting a prior period adjustment.

**Schedule D:** Schedule D is a report of waiver expenditures by waiver year for a given waiver period that is generated within the Medicaid Statement of Expenditures for the Medical Assistance Program (MBES) when selected by an MBES user from the reports menu. The State will submit a Schedule D for the previous waiver period with each renewal submission.

**Base Year:** In an Initial Waiver (i.e., first submission of a new program's cost-effectiveness data), CMS requires all States to create a BY which can be used to project total expenditures for the projected waiver period (P1 and P2). The BY must be the most recent year that has already concluded. The State must justify the use of any other year as the base year. All expenditures in the BY will be verified by the RO. The BY expenditure and enrollment data should be the actual experience specific to the population covered by the waiver. The maximum time period between a BY and P1 should be five years. CMS recommends that States use the first day of a Federal quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

**Base Year for Conversion Waivers:** In Conversion Renewal Waivers (i.e., existing waivers which will comply with these cost-effectiveness instructions ***for the first time under the new BBA regulations only***), CMS will require all States to create a BY which can be used to project total expenditures for the projected waiver periods (P1 and

P2). If possible, the BY should be a year which has already concluded and where no additional payments can be recorded. All expenditures in the BY will be verified by the RO. CMS prefers that states use 7/1/2001 – 6/30/2002 as their BY because it was prior to the announcement of the new test and would not allow states to increase costs after the announcement that there would be no retrospective review for the conversion renewal period. That base year is also complete and allows states to begin analysis in order to submit their waivers in a timely manner. If the State would like, CMS will negotiate a BY that has already been concluded other than 7/1/2001 – 6/30/2002. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to adding into waiver cost projections.*

**Caseload:** The total number of individuals enrolled on a waiver at any given time is its caseload. Because cost-effectiveness is calculated on a PMPM, the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload. The standard measurement for caseload is member months.

**Case mix:** The payments and the PMPM costs of a waiver program are affected by the distribution of the caseload among different reporting categories (MEGs in a 1915(b) waiver). The relative distribution of a member months among MEGs is referred to as membership mix or "case mix". Anytime a State has a MEG with greater than average cost and a caseload growing at a faster rate than less expensive MEGs, the overall weighted average should account for casemix changes or there will be a false impression of the waiver not being cost-effective. *For example, in a State with 100 enrolled members, MEG 1 has a PMPM cost of $3,000 and has 25% of the member months (25 member months) in the base year. MEG 2 has a PMPM cost of $300 and has 75% of the member months (75 member months) in the base year. The overall weighted PMPM for BY with the base year casemix would be:*

$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975$ $\frac{\text{BY PMPM x BY MM}}{\text{BY MM}}$ =BY PMPM With Casemix for BY

*The State projects that the casemix and costs will remain the same in the future (P1). However, if in P1, the program's casemix changes so that MEG 1 has 30% of the member months and MEG 2 has 70% of the member months in P1. The overall weighted PMPM for P1 with the P1 casemix would be:*

$\frac{(\$3000 \times 30) + (\$300 \times 70)}{100} = \$1{,}110$ $\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$ =P1 PMPM With Casemix for P1

*In this case, because MEG 1 has a high cost, a relative distribution change from MEG2 to MEG 1 artificially inflates the PMPM if the State does not account for the changes in the casemix*. The overall weighted PMPM for P1 with Casemix for BY

$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975$ $\frac{\text{P1 PMPM x BY MM}}{\text{BY MM}}$ =P1 PMPM With Casemix for BY

Throughout this document, CMS has explained when to account for casemix changes

and how to calculate those calculations. In determining whether to renew the waiver, States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. However, for the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one which accounts for casemix changes (to monitor for PMPM waiver cost-effectiveness) and another which does not account for casemix changes (to monitor for overall growth in CMS-64 expenditures). These calculations are projected in D6 and explained in the instructions and Technical Assistance Guide.

**Medicaid Eligibility Group (MEG) -** A MEG is a population reporting category usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Each State will have at least one Title XIX MEG for a Medicaid 1915(b) waiver. If the State includes MCHIP populations under 1905(U)(2) and/or (U)(3) in the 1915(b) waiver, then the State will also have at least one Title XXI MEG. Each MEG's costs will be reported on a separate 64.9 Waiver Form (64.21U Waiver Form if the MEG is for an MCHIP population). States are held accountable for member month distribution changes within MEGs, but not between MEGs. In cases where significantly different costs exist between different populations, the State should consider separate MEGs to account for the likelihood of a change in the proportion of the enrollees being served in any single reporting group. The State should recognize the impact on cost trends of the increase in the proportion of membership, which would be associated with the higher cost group when determining cost-effectiveness. The State may want to consider a more complex reporting structure, which would attempt to recognize high-cost groups separately from low-cost groups. It is in a State's interest to group populations with similar costs and similar caseload growth together. *For example, a State has a program with 100 member months - 25% of which cost $3,000 and 75% of which cost $300. The State can choose to have a single MEG with a PMPM cost of $975 or two MEGS with a weighted PMPM of $975. If the state has a distribution shift between the two population groups so that there are relatively more expensive persons costing $3,000, the State will be held accountable for that redistribution effect if it has only one MEG and will not be held accountable if the State has two MEGS. The weighted-average PMPM Casemix for BY for the single MEG is $1,110. The weighted-average PMPM Casemix for BY for two MEGs is $975.*

*One MEG*

| *Base Year PMPM Casemix BY* | | P1 PMPM Casemix BY | |
|---|---|---|---|
| *($3000 x 25) + ($300 x 75) / 100* | *= 975* | *($3000 x 30) + ($300 x 70) / 100* | = $1,110 |
| BY PMPM x BY MM / BY MM | =BY PMPM With Casemix for BY | P1 PMPM x P1 MM / BY MM | =P1 PMPM With Casemix for BY |

*Two MEGs*

| *Base Year PMPM Casemix BY* | P1 PMPM Casemix BY |
|---|---|

| | | | |
|---|---|---|---|
| *($3000 x 25) + ($300 x 75)*<br>*100* | *= 975* | *($3000 x 25) + ($300 x 75)*<br>*100* | = 975 |
| BY PMPM x BY MM<br>BY MM | =BY PMPM With Casemix for BY | (P1 PMPM x BY MM) + (P1 PMPM x BY MM)<br>BY MM | =P1 PMPM With Casemix for BY |

**Adjustments:** Each State creates budget projections in a slightly different manner than other states. To address this, CMS has identified the most common adjustments states make to base year data (in initial and conversion waivers) and R2 data (in renewal waivers). The State must document each adjustment made, what is meant by each adjustment in the State Completion Section, how that adjustment does not duplicate another adjustment made, and how each adjustment was calculated. For example, in the State Completion section, the State is asked to document the State Plan Services Trend Adjustment. The State Plan Services Trend Adjustment reflects the expected PMPM cost and utilization increases (e.g., service prices, practice patterns, and technical innovation) in the managed care program from R2 (BY for initial/conversion waivers) to the end of the waiver (P2). Trend adjustments may be State Plan service-specific. Adjustments are typically expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states may calculate a combined trend rate. Because the trend is expressed on a PMPM basis, the State should explain what is accounted for in the trend adjustment (i.e., cost and utilization increases). Any trend should not be duplicated in the State's adjustments for programmatic/policy/pricing adjustments. For example, a Legislative price increase would be explained and reflected in the programmatic/policy/pricing adjustment not under the State Plan Services Trend Adjustment. The State should document how the adjustments are unique and separate.

**Trend:** Growth in spending from one year to the next year. Growth may be due to cost and utilization increases. Growth due to external forces such as Legislative change or program/contract change should be documented separately under adjustments that include more than trend. If only a trend adjustment is allowed, then growth due to external forces is not allowed without a separate waiver amendment documenting additional savings. In this preprint, all adjustments are made on a PMPM basis. For the sake of simplicity, whenever trend appears alone it refers to a PMPM increase in the cost.

**Comprehensive Waiver Criteria:** When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test: 1) Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority; 2) Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc); or 3) State Plan services were procured using sole source procurement.

**Expedited Test:** States with waivers meeting requirements for the Expedited Test do

not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. To be able to use the Expedited Test for a particular waiver, a State would need to:
Submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria (see above) OR Submit a 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver, which meets the Comprehensive Waiver Criteria except for the transportation and dental waivers specifically exempted.

**Projections in Renewal Waivers:** In Renewal Waivers, State will use its actual experience R1 and R2 data to project its P1 and P2 expenditures from the endpoint of the previous waiver of R2. In each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

**Projected Waiver Period:** P1 and P2 are projections of the Medicaid waiver program expenditures for the future two-year period for the population covered by the waiver.

**Retrospective Waiver Period:** R1 and R2 are the actual Medicaid waiver program expenditures in the historical two-year period for the population covered by the waiver. These R1 and R2 costs are compared to the P1 and P2 projections from the previous waiver submission. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to developing waiver cost projections.*

**1915(b)(3) service:** An additional service for beneficiaries approved under the waiver paid for out of waiver savings. The service is not in the State's approved State Plan. Capitated 1915(b)(3) services must have actuarially sound rates based only on approved 1915(b)(3) services and their administration subject to RO prior approval.

**Acronyms used in this section**
ADM - Administration
AI/AN – American Indian/Alaskan Native
BBA – Balanced Budget Act of 1997
BY – Base Year
CAP - cost allocation plan amendment
CE – Cost Effectiveness
CMS – Centers for Medicare and Medicaid Services
Co. - County
CSHCN – Children with Special Health Care Needs
CY – Calendar Year

DRG - Diagnostic Related Group
DSH - Disproportionate Share Hospital Payments
EQR – External Quality Review
FFP – Federal Financial Participation
FMAP – Federal Medical Assistance Participation
MAP – Medical Assistance Program or services
FFS – fee-for-service
FQHC – Federally Qualified Health Center
FY- Fiscal Year
GME – Graduate Medical Education
HIO – Health Insuring Organization
MBES - Medicaid Statement of Expenditures for the Medical Assistance Program
MCO – Managed Care Organization
MCHIP – Medicaid-Expansion Children's Health Insurance Program
MEG – Medicaid Eligibility Group
MMIS – Medicaid Management Information System
P1 – Prospective Year 1
P2 – Prospective Year 2
PAHP - Prepaid Ambulatory Health Plan
PCCM – Primary Care Case Manager
PIHP – Prepaid Inpatient Health Plan
PMPM – Per Member Per Month
RHC – Rural Health Center
SPA – State Plan Amendment
PRO – Peer Review Organization
Q1 – Quarter 1
Q4 – Quarter 4
Q5 – Quarter 5
R1 – Retrospective Year 1
R2 – Retrospective Year 2
RO – Regional Office
SCHIP – State Children's Health Insurance Program
SURS - Surveillance and Utilization Review System
Title XIX – Medicaid
Title XXI - State Children's Health Insurance Program
TPL – Third Party Liability
UPL – Upper Payment Limit

## II. General Principles of the Cost-Effectiveness Test

1. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. In order to grant a 1915(b) waiver, a State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. The State will document program expenditures on the CMS- 64 for the same two-year period for the population covered by the waiver. In other words, a State initially projects spending and documents on an on-going basis that the actual expenditures are at or below the projected amount.

2. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that it was cost-effective during the retrospective two-year period and must create waiver cost projections that will be used to determine cost-effectiveness for the prospective two-year period. The cost-effectiveness test is applied to the combined two-year waiver period, not to each individual waiver year or portion of a year.

3. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. States no longer need to demonstrate that "with waiver" costs are lower than "without waiver" costs. Instead, States must demonstrate that their waiver projections are reasonable and consistent with statute, regulation and guidance. Retrospectively, the State will document that program expenditures were less than or equal to these projections. As with all elements of 1915(b) waivers, States may amend their cost-effectiveness projections if the waiver program changes or if additional information documents that the projections are inaccurate and should be modified accordingly.

4. Each Initial Waiver submission will include a State's projected expenditures for the upcoming two year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2).

5. For each Renewal Waiver submission, a State will demonstrate cost-effectiveness for the retrospective waiver period by showing that the actual expenditures for retrospective years one and two (R1 and R2) did not exceed what the State had projected it would spend (P1 and P2) for the same two-year period on a per member per month (PMPM) basis for the population covered by the waiver. In other words, a State must compare what it had initially projected it would spend to what it actually spent over the waiver period and show that the actual expenditures came in at or under the projected amount. *Please note that for Conversion Waivers, CMS will not require a retrospective cost-effectiveness test. The State is only allowed a single Conversion Waiver, the first time the State submits a waiver renewal after the announcement of this new method.*

6. In order to project expenditures for the prospective waiver period, a State must

use the actual historical expenditures from its base year (for an initial or conversion waiver) or from the past waiver period (R1 & R2 for a renewal waiver) as the basis for its cost effectiveness projection, adjusting for future changes in trend (including utilization and cost increases), and other adjustments acceptable to CMS. By always using actual historical expenditures from the most recent waiver period as the basis for the projection, the cost-effectiveness test for a waiver program will be "rebased" upon each renewal. *Note: this applies to both capitated and FFS services within 1915(b) waivers. The State must document that actual costs claimed on the CMS-64 were used to document the Actual Waiver Cost in Appendix D3.*

7. All 1915(b) waivers will use this cost-effectiveness test, regardless of the type of waiver program or the delivery system under the waiver.

8. All Medicaid Medical Assistance program expenditures (fee-for-service and capitated services) related to the services covered by the waiver will be reported for the population enrolled in the waiver. Because waiver providers can affect the costs of services not directly included in the waiver, CMS is requiring that States include **all Medicaid Medical Assistance program expenditures related to the population and services covered by the waiver, not just those services under the waiver,** in developing their cost-effectiveness calculations. See the detailed instructions below for additional guidance.

9. CMS will evaluate cost-effectiveness based on all Medicaid expenditures for waiver enrollees impacted by the waiver, even those expenditures that are outside the capitation rate or do not require a PCCM referral. These services are generally referred to as "wrap-around" or "carved-out" services and may include such services as pharmacy or school-based services that may be paid on a fee-for-service (FFS) basis for the population covered by the waiver. See the detailed instructions below for additional guidance. Additional guidance is also available in the technical assistance guide for cost-effectiveness. Each State will need to work with CMS to determine whether or not services that are not explicitly under the waiver should be included in the cost-effectiveness calculations.

10. Because all affected Medicaid Medical Assistance program expenditures for waiver enrollees will be counted in cost-effectiveness calculations, there will essentially be no difference in the extent to which services are impacted by either a PCCM system or capitated program cost-effectiveness test. Initial waivers with both PCCM and capitated delivery systems may need to make some specific adjustments in PCCM system expenditures as noted in the **State Completion Section D.IV.I Special Note for Capitated and PCCM combined initial waivers**.

11. State administrative costs associated with the program and population enrolled in the waiver will also be reported. Administrative costs include, but are not limited

to, State expenditures such as enrollment broker contracts, contract administration, enrollee information and outreach, State utilization review and quality assurance activities, State hotline and member services costs, the cost of an Independent Assessment, External Quality Review (EQR), actuary contracts, and administrative cost allocation (salaries).

12. All administrative and service costs should be calculated on a per member/per month basis. States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. States should have total PMPM actual waiver expenditures for the two-year period equal to or less than the corresponding total PMPM projected waiver expenditures for that same period. For the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one examining aggregate projected spending compared to the aggregate CMS-64 totals and the second examining PMPM spending compared to PMPM projections. *See the instructions for Appendix D6 for the explanation of the two calculations and detailed instructions on how to calculate and monitor each test.* **For the ultimate decision of cost-effectiveness (i.e. the decision to renew each waiver), the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.**

13. Cost-effectiveness will be calculated on a total PMPM basis, which is comprised of both service and administration costs.

14. CMS will track and evaluate waiver cost effectiveness using expenditure data as reported on the CMS-64 and will be measured in total computable dollars (Federal and State share). All waiver expenditures will be reported on the CMS-64.9 Waiver, CMS-64.21U Waiver, or CMS-64.10 Waiver forms on a quarterly basis. (Data from the CMS-64.21U Waiver form will be used if the State enrolls its Medicaid-expansion SCHIP population in the waiver.)

15. All expenditures are based on the CMS-64 Waiver forms, which are based on date of payment, not date of service. States will itemize all expenditures for the population covered under the Waiver into each of the main service categories in the CMS-64 Waiver forms. These forms have been cleared by OMB (No. 0938-0067). The *Form CMS-64.9 Waiver* for Medical Assistance payments includes the major categories of service: inpatient hospital services, physician services, dental, clinic, MCO capitation, etc. Administrative expenditures will be reported on the CMS-64.10 Waiver form accordingly. *Note: please ensure that the State's projections for initial, conversion, and renewal waivers are projections for date of payment as well.*

16. States with multiple 1915(b), 1915(c), and 1115 waivers that have overlapping waiver populations will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the *CMS-64 Summary*.

17. All actual expenditures reported and used as the basis for a cost effectiveness projection must be verified by the RO.

18. The expenditures and enrollment numbers for voluntary populations (i.e., populations that can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in State's 1915(b) waiver. In general, CMS believes that voluntary populations should not be included in 1915(b) waivers. If the State wants to include voluntary populations in the waiver, then the expenditures and enrollment numbers for that population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in their waiver are required to submit a written explanation of how selection bias will be addressed in the waiver cost-effectiveness calculations. *Note: This principle does not change the historic practice of requiring States to include the experience of a voluntary MCO population in a mandatory PCCM waiver if a beneficiary can be auto-assigned to one of the delivery systems.*

19. States with 1932 managed care SPA programs with an overlapping 1915(b) waiver will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the CMS-64 Summary.

20. Incentive payments will be included in the cost effectiveness test. Incentives included in capitated rates are already constrained by the Medicaid managed care regulation at §438.6(c) to 105% of the capitated rates based on State Plan services. If there are any incentives in FFS/PCCM, those payments must be applied under the cost-effectiveness test. For example, if PCCM providers are given incentives for reducing utilization, the incentives are limited to the savings of State Plan service costs under the waiver. This policy creates a restraint on the FFS/PCCM incentive costs. States should ensure that all incentives are reported in renewal Actual Waiver Costs in **Appendix D3**.

21. 1915(b)(3) waiver services will be included in the cost effectiveness test. In general, States cannot spend more on 1915(b)(3) services than they would save on State Plan services.

22. Cost Effectiveness requirements apply to Medicaid Expansion SCHIP populations under 1905(U)(2) and (U)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(U)(2) and (U)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program in the Medicaid delivery system.

23. Comprehensive Waiver Criteria - When a person or population in a waiver

receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test:

- Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority,
- Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc), or
- State Plan services were procured using sole source procurement (Sole source procurement means non-open, non-competitive procurement not meeting the requirements at 45 CFR 74.43). States must utilize the Comprehensive Cost Effectiveness Test to apply for and renew 1915(b) waivers that award services contracts using procurement methods meeting the criteria in 45 CFR 74.44 (e). Most competitive procurements resulting in a single contractor are not considered sole-source procurement under the 45 CFR 74.44(e) criteria. The State should verify the regulatory requirements and use the expedited test only if all expedited criteria are met.

24. Expedited Test – CMS is proposing a waiver-by-waiver test to expedite the processing of certain renewal waivers. States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. States will simply submit *Schedule D* and the most recent 8 quarters of waiver forms from MBES to CMS along with projections for the upcoming waiver period (**Appendix D1, D2.S, D2.A, D4, D5, and D6**). For additional guidance, please see the Cost-effectiveness Technical Assistance Manual. To be able to use the Expedited Test for a particular waiver, a State would need to:

- Submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria OR
- Submit a 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver which meets the Comprehensive Waiver Criteria except for transportation and dental waivers as noted below.

25. Cost-effectiveness for waivers of only transportation services or dental pre-paid ambulatory health plans (PAHPs) are processed under the expedited test if the transportation or dental waiver alone meets the expedited criteria. In this instance, States should not consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. If enrollees in a transportation or dental waiver are also enrolled in pre-paid inpatient health plans (PIHPs), MCOs, or PCCMs under separate waivers or separate SPA authority, the costs associated with dental or transportation services should not be included in any other 1915(b) waiver cost effectiveness test.

## III. Instructions for Appendices
## Step-by-Step Instructions for Calculating Cost-Effectiveness

### Appendix D1 – Member Months

Document member months in the Base Year (BY)/ Retrospective Waiver Period (R1 and R2) and estimate projected member months in the upcoming period (P1 and P2) on a quarterly basis. Actual enrollment data for the retrospective waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed for RO monitoring on a quarterly basis. States will not be held accountable for caseload changes. This data is also useful in assessing future enrollment changes in the waiver.

States must document the number of member months in the waiver for the retrospective waiver period (R1 and R2) for renewal waivers and in the base year (BY) for initial and conversion waivers

For initial or conversion waivers, document member months from the Base Year (BY). For renewal waivers, document member months from Retrospective Waiver Period (R1 and R2). Categorize all enrollees into Medicaid Eligibility Groups (MEG). A MEG is usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Please note that States will use these same MEGs to report expenditures on the CMS 64.9 Waiver, CMS 64.10 Waiver, and/or CMS 64.21U Waiver.

CMS recommends that the State analyze their capitated program's rate cell categories to support the development of the Medicaid Eligibility Group (MEG) detail within the cost-effectiveness analysis. A MEG is a reporting group collapsing rate cell categories into groups that the State anticipates will have similar inflation and utilization trends, as well as by program structure (eligibility, geography, service delivery, etc). Every MEG created will mean a separate CMS 69.9 Waiver form, etc and results in additional quarterly expenditure reports to CMS. Selecting the right number of MEGs is a very important step. *See the MEG definition above for further guidance.* States should use the 64.9 and 64.21 waiver form population categories for any renewals. *For example, Nebraska chose to divide their single waiver into four MEGs. Nebraska has Medicaid Expansion SCHIP populations in their 1915(b) waiver, which automatically means that 2 MEGs are necessary (one for TXIX and one for MCHIP). In addition, Nebraska chose to separate costs for Special Needs children's populations and AI/AN populations from all other enrollees because of the structure of their program and differential caseload trends that they anticipate. During the waiver, Nebraska will report waiver costs on two separate 64.9 Waiver forms ((Medicaid (No CSHCN or AI/AN – PIHP only), and Medicaid (CSHCN or AI/AN– MCO/PIHP/PCCM) and two separate 64.21U Waiver forms (MCHIP (No CSHCN or AI/AN– PIHP only), MCHIP (CSHCN or AI/AN – MCO/PIHP/PCCM)). In Nebraska's renewal they would have a MEG for each of the four populations)*.

**Step 1.** List the Medicaid Eligibility Groups (MEGs) for the waiver. List the base year eligible member months by MEG. Please list the MEGs for the population to be

enrolled in the waiver program. The number and distribution of MEGs will vary by State. For renewals, if the State used different **MEGs** in R1 and R2 than in P1 and P2, please create separate tables for the two waiver periods (the state will be held accountable for caseload changes between MEGs in this instance). The base year for an initial waiver should be the same as the FFS data used to create the PMPM Actual Waiver Costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted in the Appendix and explained in the State Completion Section of the Preprint.

**Step 2.** Project by quarter, the number of member months by MEG for the population that will participate in the waiver program for the future waiver period (P1 and P2). The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in R1 and R2. List the quarterly member/eligible months projected in each MEG by quarter. States who are phasing in managed care programs or populations may choose to have quarterly estimates that are not equal (i.e., P1 Q1 reflects a different enrollment than P1 Q4).

**Step 3.** Total the member/eligible months for each quarter and year. Calculate the annual and quarterly rate of increase/decrease in member months over the projected period. Explain the rate of increase/decrease in the State Completion section.

**Appendix D2.S - Services in Waiver Cost**
Document the services included in the waiver cost-effectiveness analysis.

**Step 1.** List each State Plan service and 1915(b)(3) service under the waiver and indicate whether or not the service is:

- State Plan approved;
- A 1915(b)(3) service;
- A service that is included in a capitation rate; paid to either MCOs, PIHPs, or PAHPs, (whichever is applicable);
- A service that is not a waiver service but is impacted by the MCOs, PIHPS, or PAHPs (whichever is applicable);
- a service that is included in the PCCM FFS reimbursement.

The chart in **Appendix D2.S** should be modified to reflect each State's actual waiver program. States should indicate which services are provided under each MEG, if the benefit package varies by MEG. Modify columns as applicable to the waiver entity type and structure to note services in different MEGs.

**Step 2.** Please note any proposed changes in services on Appendix D2.S with a *. *See the Nebraska example for illustration purposes.*

**Step 3.** List the State Plan Services included in the Actual Waiver costs (only State Plan Service costs may be included in an initial waiver's Actual Waiver Costs). Please also list the 1915(b)(3) non-State Plan services proposed in the initial waiver and any 1915(b)(3) services included in the Actual Waiver costs for a conversion or renewal

waiver. For an MCO/PIHP/PAHP waiver, include services under the capitated rates, as well as services provided to managed care enrollees on a fee-for-service wraparound basis (note each). For a PCCM program, include services requiring a referral, as well as services provided to waiver enrollees on a wraparound basis. Please add lines and specify as needed.

**(Column B Explanation) Services**: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

**(Column C Explanation) State Plan Approved**: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

**(Column D Explanation) 1915(b)(3) waiver services**: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

**(Column E Explanation) MCO Capitated Reimbursement**: Check this column if this service will be included in the capitation or other reimbursement to the MCO. If a 1915(b)(3) service in an MCO is capitated, please mark this column.

**(Column F Explanation) Fee-for-Service Reimbursement impacted by MCO**: Check this column if the service is not the responsibility of the MCO, but the MCO or its contracted providers can affect the utilization, referral or spending for that service*. For example, if the MCO is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO will impact pharmacy use because access to drugs requires a physician prescription*. Do not mark services NOT impacted by the MCO and not included in the cost-effectiveness analysis. *For example, a State would not include Optometrist screening exams in states where vision services are not capitated, a PCP referral is not required for payment, and PCP do not refer or affect patient access to vision screening examinations.*

**(Column G Explanation) PCCM Fee-for-Service Reimbursement:** Check this column if this service will be included in the waiver and will require a referral/prior authorization or if the service is not covered under the waiver and does not require a referral/prior authorization, but is impacted by it. For example, a goal of most primary care case management programs is that emergency services would be reduced. For example, if

the State pays for pharmacy on a FFS basis, but does not require a referral from the primary care case manager to process those claims, the primary care case manager will still impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the waiver. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

**(Column H Explanation) PIHP Capitated Reimbursement**: Check this column if this service will be included in the capitation or other reimbursement to the PIHP. If a 1915(b)(3) service is capitated in a PIHP, please mark this column.

**(Column I Explanation) Fee-for-Service Reimbursement impacted by PIHP**: Check this column if the service is not the responsibility of the PIHP, but is impacted by it. For example, if the PIHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PIHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PIHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

**(Column J Explanation) PAHP Capitated Reimbursement**: Check this column if this service will be included in the capitation or other reimbursement to the PAHP. If a 1915(b)(3) service is capitated in a PAHP, please mark this column. *Note: the Nebraska example did not include a PAHP and so did not include this column.*

**(Column K Explanation) Fee-for-Service Reimbursement impacted by PAHP**: Check this column if the service is not the responsibility of the PAHP, but is impacted by it. For example, if the PAHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PAHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PAHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance. Note: the Nebraska example does not include a PAHP delivery system and so did not include this column.*

Note: Columns C and D are mutually exclusive. Columns E and F are mutually exclusive for the MCO program. Columns H and I are mutually exclusive for the PIHP program. Columns J and K are mutually exclusive for the PAHP program. Each service should have a mark in columns C or D. If the State has more than one MEG, Appendix D2 should reflect what services are included in each MEG.

**Chart: Inclusion of Services in Cost-Effectiveness Test**
Note: All references to the single CMS 64.9 Waiver form refer to a 1915(b) waiver that does not include any SCHIP Medicaid expansion populations. If a 1915(b) includes an SCHIP Medicaid expansion population, the State would also complete a CMS 64.21U Waiver form for the applicable SCHIP Medicaid expansion population. In addition, the State can always choose to divide its data into **MEGs** for additional reporting categories. Services included in other 1915(b) waivers should be excluded and not counted under two separate 1915(b) cost-effectiveness tests. Services in 1915(c) waivers should only

be included for concurrent 1915(b)/1915(c) waivers. Services for 1115 Demonstration waivers should only be included if the 1915(b) population is being used as an impacted population in the 1115 Demonstration. *See the Technical Assistance Manual for additional information.*

| Example | Type of Delivery System | Services Under 1915(b) waiver | Services included in Cost Effectiveness Test | Services excluded from Cost Effectiveness Test |
|---|---|---|---|---|
| Medicaid beneficiary is enrolled only in 1915(b) for transportation | PAHP | Transportation only | Transportation | All other Medicaid services |
| Medicaid beneficiary is enrolled only in 1915(b) for dental | PAHP | Dental only | Dental | All other Medicaid services |
| Medicaid beneficiary is enrolled only in 1915(b) for mental health – remaining services are FFS or under 1932 SPA *(examples: rural Nebraska and Iowa)* | PIHP | Mental Health and Substance Abuse are under waiver. Pharmacy, rehabilitation services, and inpatient psychiatric services for individuals under age 21 are fee-for-service. | All Mental Health, Substance Abuse, Pharmacy, Inpatient psychiatric services for individuals under age 21, and Rehabilitation services for waiver enrollees are reported on single *CMS-64.9 Waiver form* for the 1915(b) waiver. | All other Medicaid services |
| Medicaid beneficiary is enrolled in one 1915(b) waiver for mental health and MCO services *(examples: urban Nebraska special needs children)* | PIHP and MCO | All services | All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form* | None. |
| Medicaid beneficiary is | PIHP and MCO | All services except pharmacy are in one | The State divides all services for | None. |

| Example | Type of Delivery System | Services Under 1915(b) waiver | Services included in Cost Effectiveness Test | Services excluded from Cost Effectiveness Test |
|---|---|---|---|---|
| enrolled in 1915(b) for mental health and separate 1915(b) for MCO | | waiver or the other | waiver enrollees into two *CMS-64.9 Waiver forms*: one for the mental health 1915(b) and the other for the MCO 1915(b). | |
| Medicaid beneficiary is enrolled in a single1915(b) for mental health and PCCM *(examples: urban Nebraska special needs children)* | PIHP and PCCM | All services except school-based services | All services including school-based services for waiver enrollees are reported on a *CMS-64.9 Waiver form* | None. |
| Medicaid beneficiary is enrolled in 1915(b) PCCM or MCO | PCCM and/or MCO | All services | All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form* | None. |

**Appendix D2.A Administrative Costs in the Waiver**
Document the administrative costs included in the Actual Waiver Cost.

**Step 1.** Using *CMS-64.10 Waiver Form* line items numbers and titles, document the State's administrative costs in the waiver. **Do not include MCO/PIHP/PAHP/PCCM entity administration costs.** For initial waivers, this will include only fee-for-service costs such as MMIS and SURS costs. For renewal waivers and conversion waivers, the administrative costs will include managed care costs such as enrollment brokers, External Quality Review Organizations, and Independent Assessments. Add lines as necessary to distinguish between multiple contracts on a single line in the CMS-64.10. *Note: PCCM case management fees are not considered State Administrative costs because CMS matches those payments at the FMAP rate and states claim those costs on the CMS-64.9 Waiver form. Services claimed at the FMAP rate should be reported on **Appendix D2.S** and not reported on **Appendix D2.A**.*

**Step 2.** The State should allocate administrative costs between the Fee-for-service and managed care program depending upon the program structure. For example, for an MCO program, the State might allocate the administrative costs in the Administrative

Cost Allocation Plan to the MCO program based upon the number of MCO enrollees as a percentage of total Medicaid enrollees. For a mental health carve out enrolling most Medicaid beneficiaries in the State, allocate costs based upon the mental health program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. Explain the cost allocation process in the preprint.

**Appendix D3 – Actual Waiver Cost**

Document Base Year and Retrospective Waiver Period expenditures (actual expenditures in the BY for initial/conversion waivers and R1 and R2 in renewal waivers). States that are eligible to use the expedited process for certain waivers need not complete Appendix D3; instead, attach the most recent waiver Schedule D. For all other submissions, States should complete **Appendix D3**.

The State must document the total expenditures for the services impacted by the waiver as noted in **Appendix D2**, not just for the services under the waiver. For an Initial Waiver or Conversion Waiver, the State must document the expenditures used in the BY PMPM. **All expenditures in the BY will be verified by the RO.** For a Renewal Waiver, the State must document the actual expenditures in the retrospective two-year period (R1 and R2) separating administration, 1915(b)(3), FFS incentives, capitated, and fee-for-service State Plan expenditures as noted. **Actual expenditures will be verified by the RO on a quarterly basis by comparing projections to actual expenditures and other routine audit functions.**

The actual expenditures used in the cost-effectiveness calculations should include all Medicaid program expenditures related to the population covered by the waiver, not just those services directly included in the waiver. If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64. Incentives to capitated entities are reflected in **Column D of Appendix D3** of the spreadsheets. Fee-for-service incentives, such as incentives to PCCM providers, are noted separately in **Column G of Appendix D3**. 1915(b)(3) services in the initial waiver will always be zero in **Column H of Appendix D3** of the initial waiver because 1915(b)(3) services are a result of savings under the waiver and cannot exist prior to the waiver.

Actual expenditures are based on the CMS-64 Waiver forms, which are based on date of payment not date of service.

States must separately document actual Medical Assistance service expenditures and actual State administrative costs related to those services. Actual case management fees paid to providers in a PCCM program should be included as service expenditures.

Since a State may be in the process of developing a Renewal Waiver during the second year of the waiver (R2) period (to avoid an extension), the State should project the remaining period of time for which actual expenditures are not yet available for R2 (approximately 6 months). If the State projects any portion of R2, please document

those projections and the assumptions made.

Should a State request and be granted one or more 90-day temporary extension(s) for submitting a Renewal Waiver, the following process applies depending on the length of the extension:

- For three or fewer 90-day temporary extensions (a period of less than one year after the expiration of the waiver), the State must demonstrate cost-effectiveness over the original two-year period included in the waiver. In other words, if a waiver considered years CY 2003 and CY 2004 as P1 and P2, respectively, and 2 three-month temporary extensions were obtained, the State would still be required to demonstrate cost-effectiveness for calendar year 2003 and 2004 by comparing actual expenditures (R1 and R2) to the projected expenditures (P1 and P2) for these two years in aggregate. In this scenario, actual expenditures for the entire R2 period may be available to support the Renewal Waiver calculations.
- For four or more temporary extensions (a period of one year or more after the expiration of the waiver), the State must demonstrate cost-effectiveness for the original two-year period included in the waiver as previously described and in addition demonstrate cost-effectiveness for the one-year extension period (to the extent data is available – in this case CY2005). In this scenario, actual expenditures for the entire R2 period will be available to support the Renewal Waiver calculations, but the extension year may require projecting actual expenditures. The State's extension year will be compared to the expenditure projections as if P2 were 24 months rather than 12 months.

| Number of Extensions | Demonstration of Cost-Effectiveness | Example |
|---|---|---|
| 3 or fewer 90-day temporary extensions | Demonstrate cost-effectiveness for the original two-year period | Waiver CY2003 and CY2004<br>2 Extensions through 7/1/2005<br><br>State CE covers only CY2003 and CY2004 |
| 4 or more temporary 90-day extensions | Demonstrate cost-effectiveness for the original two-year period and for each additional one-year extension period | Waiver CY2003 and CY2004<br>4 Extensions through CY2005<br><br>State CE covers CY2003, CY2004, and CY2005 |

Fee-for-service Institutional UPL Expenditures to include and not include in the cost-effectiveness analyses.

- **Transition amounts should be excluded** from the Cost-Effectiveness test. A transition amount is what the State spent over 100% of the institutional fee-for-service UPL (i.e., the "excess"). The State should isolate the excess amounts to remain in fee-for-service outside of the waiver and include only the amount under 100% of the FFS UPL in the Cost-effectiveness analysis.

- **Supplemental payments at or below 100% of the UPL should be included** in the cost-effectiveness analysis. States that are not transition States may in fact make supplemental payments below or up to the 100% UPL and that money should be included in the cost-effectiveness. The entire amount of the supplemental payment at or below the UPL should be in the 1915(b) analysis.

**States should contact their RO for additional State-specific guidance on the inclusion and exclusion of Fee-for-service Institutional UPL payments.**

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.** The renewal will list the MEGS twice – once for R1 and once for R2. *See the example spreadsheets.*

**Step 2.** List the BY eligible member months (R1 and R2 member months, if a renewal). *See the example spreadsheets.*

**Step 3.** List the base year (R1 and R2 if a renewal) aggregate costs by MEG. Actual cost and eligibility data are required for BY (R1 and R2) PMPM computations. Aggregate Capitated Costs are in Column D. Aggregate FFS costs are in Column E. Add D+E to obtain the State Plan total aggregate costs in Column F. List FFS incentives in Column G. In a renewal or conversion waiver, list 1915(b)(3) aggregate costs in Column H. List Administrative costs in Column I. For an initial waiver, these PMPM costs are derived from the State's MMIS database or as noted from the explanation in the State Completion section under **Section D.IV.I.c**. Comprehensive Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D and with additional ad hoc reporting for 1915(b)(3) services and FFS incentive payments. The State must track FFS incentive and 1915(b)(3) payments separately (those costs will not be separately identified on Schedule D). The State must document that State Plan service aggregate costs amounts were reduced by the amount of FFS incentives and 1915(b)(3) costs spent by the State. To calculate the PMPM by MEG for 1915(b)(3) services, the State should divide the cost of 1915(b)(3) service costs by MEG for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for FFS incentives, the State should divide the cost of FFS incentives for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for State Plan Services, the State should divide the cost of State Plan Services from Schedule D (minus FFS incentives and 1915(b)(3) service costs) for R2 and divide by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application. The portion of R2 that is actual should match the Schedule D submitted.*

**Step 4.** Total the base year capitated costs and fee-for-service costs to derive the total base year costs for services. Add all costs (F, G, H, and I) to obtain total waiver aggregate costs.

**Step 5.** Divide the base year (BY) costs by the annual BY (divide the R1 costs by the R1 MM or the R2 costs by the R2 MM, if a renewal) member months (MM) to get PMPM base year (R1 or R2) costs**.** In this instance, the State calculates the overall PMPM for BY (the overall PMPM for R1 or the overall PMPM for R2 in a renewal). The State will divide the costs of the program by the caseload for the same year from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each year of the waiver (R1 and R2). In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

| Initial/Conversion | Renewal R1 | Renewal R2 |
|---|---|---|
| BY Costs<br>BY MM | R1 Costs<br>R1 MM | R2 Costs<br>R2 MM |
| Overall PMPM for BY | Overall PMPM for R1 | Overall PMPM for R2 |

**Appendix D4 – Adjustments in the Projection**
Document adjustments made to the BY or R1 and R2 to calculate the P1 and P2. The State will mark the adjustments made and document where in Appendix D5 the adjustment can be found. All adjustments are then explained in the State Completion portion of the Preprint.

**Waiver Cost Projection Adjustments:** On **Appendix D4**, check all adjustments that the State applied to the R1/R2 or BY data. In Column D, note the location of each adjustment in **Appendix D5**. Note: only the adjustments listed may be made. If the State has made another adjustment, the State should obtain CMS approval prior to its use. Complete the attached preprint explanation pages and include attachments as requested. ***Note:*** *(Initial Waiver only) Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- some adjustments to the Waiver Cost Projection in an initial waiver must be made due to a policy decision in the capitated program. Those adjustments are permitted only to the capitated programs and need an offsetting adjustment to the PCCM Waiver Cost Projections in order to make the PCCM costs comparable to the Actual Waiver Costs. Please see the State Completion Section of the initial waiver for further instructions if the State has a combined capitated and PCCM cost-effectiveness analysis.*

**Appendix D5 – Waiver Cost Projection**
Each time a waiver is renewed, a State must develop a two-year projection of expenditures. States must calculate projected waiver expenditures (P1 and P2) for the upcoming period. Projected waiver expenditures for P1 and P2 should be created using the State's actual historical expenditures (e.g., BY data for an Initial or Conversion Waiver, or R2 data using R1 & R2 experience to develop trends for a Renewal Waiver)

for the population covered under the waiver and adjusted for changes in trend (including utilization and cost increases) and other adjustments acceptable to CMS. For example, in an Initial or Conversion Waiver, a State should use its actual BY data to project its P1 and P2 expenditures. In a Renewal Waiver, a State should use its actual experience in R1 and R2 to project trends for its P1 and P2 expenditures from the endpoint of the previous waiver of R2. As a result, in each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2.

Projected waiver expenditures must include all Medicaid expenditures for the population included in the waiver, not just those services directly included in the waiver, calculated on a PMPM basis and including administrative expenses. (For example, a State must include services that are outside of the capitated or PCCM program.) If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64.

In projecting expenditures for the population covered by the waiver, States must use trends that are reflective of the regulation requirements for capitated rates and fee-for-service history for fee-for-service rates. The State must document and explain the creation of its trends in the State Completion Section of the Preprint. CMS recommends that a State use at least three years of Medicaid historical data to develop trends. States must use the State historical trends for the time periods where actual State experience is available. States must use the prescribed methods (see the State Completion Section) for inflating FFS incentives (no greater than the State Plan trend rate), 1915(b)(3) services (the lower of State Plan service and actual 1915(b)(3) trend rates), and administration (historic Medicaid administration trend rates unless the State is using sole source procurement to procure State Plan services)

States need to make adjustments to the historical data (BY for initial/conversion and R2 for renewals) used in projecting the future P1 and P2 PMPMs to reflect prospective periods. For Renewals, these adjustments represent the impact on the cost of the State's Medicaid program from such things as: State Plan service trend, State Plan programmatic/policy/pricing changes, administrative cost adjustments, 1915(b)(3) service trends, incentives (not in the capitated payment) adjustments, and other. Since States are required to consider the effect of all Medicaid costs for the waiver population, States should consider adjustments that might impact costs for services not directly covered under the waiver (i.e., global changes to the Medicaid program).

1915(b)(3) services must be paid out of savings in the future years (P1 and P2) of the waiver. Under 1915(b)(3) authority, states can offer additional benefits using savings from providing State Plan services more efficiently. The following principles and requirements will be used to evaluate the cost-effectiveness of waiver requests that include 1915(b)(3) services. The principles are intended to highlight concepts and policy goals (i.e., **what** the policy guidance is intended to accomplish). The requirements are intended to outline operational details (i.e., **how** the policy goals will

be pursued).

**1) Aggregate spending**

- *General principle*—Under a 1915(b) waiver, combined spending on State Plan and 1915(b)(3) services cannot exceed what would have occurred without the waiver. In other words, States cannot spend more on 1915(b)(3) services than they save on State Plan services under the waiver.
  - *Requirement*—Combined spending on State Plan and 1915(b)(3) services cannot exceed projected spending during any given waiver period.

**2) Base-year spending (R2 for renewals) (for waiver projections)**

- *General principle one*—Spending for 1915(b)(3) services should not exceed the cost of providing these services.
- *General principle two*—Spending for 1915(b)(3) services should not exceed the "budget" for these services, as determined in a state's waiver application.
  - *Requirement (for initial waiver applications)*—The base year amount for 1915(b)(3) services under a new waiver application is limited to the lower of:
    a. Expected costs for the 1915(b)(3) services or
    b. Projected savings on State Plan services
  - *Requirement (for Renewals and Conversion Renewals)*—The base year (R2 for renewals) amount for projecting spending on 1915(b)(3) services under a waiver renewal is limited to the lower of:
    a. Actual costs for 1915(b)(3) services under the current waiver or
    b. Projected costs for 1915(b)(3) services under the current waiver (P2 in the previous submittal)

**3) Growth in spending (price increases and use of services, but not changes in enrollment)**

- *General principle one*—Growth in spending on 1915(b)(3) services cannot exceed growth in spending for State Plan services under the waiver. (This ensures that savings on State Plan services for both initial waiver and renewal periods finance spending for 1915(b)(3) services.)
- *General principle two*—Growth in spending on 1915(b)(3) services cannot exceed historical growth in spending for these services. (This ensures that growth in spending on waiver services is reasonable for the particular services.)
  - *Requirement*—Growth in spending for 1915(b)(3) services is limited to the lower of:
    a. The overall rate of trend for State Plan services, or
    b. State historical trend for 1915(b)(3) services

**4) Covered services**

- *General principle*—If a state wants to expand 1915(b)(3) services, the State must realize additional savings on State Plan services to pay for the

new services.

- *Requirement*—Before increasing its budget for 1915(b)(3) waiver services, a state must submit an application to CMS to modify its waiver (or document the modification in its renewal submittal). This application must show both:
  a. How additional savings on State Plan services will be realized, and
  b. That the savings will be sufficient to finance expanded services under the waiver
- *Special case*—A state also could be required to cut back (b)(3) services because of increased use of State Plan services.

**5) Payments**

- *Requirement*—As a condition of the waiver, capitated 1915(b)(3) payments must be calculated in an actuarially sound manner.

States must calculate a separate capitation payment for 1915(b)(3) services using actuarial principles and the same guiding principles as the regulation at 42 CFR 438.6(c) -with the exceptions that the 1915(b)(3) rates are based solely on 1915(b)(3) services approved by CMS in the waiver and the administration of those services. The actual payment of the 1915(b)(3) capitated payment can be simultaneous with the payment of the State Plan capitated payment and appear as a single capitation payment. However, the State must be able to track and account for 1915(b)(3) expenditures separately from State Plan services.

1915(b)(3) services versus 42 CFR 438.6(e) services. Under a 1915(b) waiver, 1915(b)(3) services are services mandated by the State and paid for out of State waiver savings. 42 CFR 438.6(e) services are services provided voluntarily by a capitated entity out of its capitated savings. A State cannot mandate the provision of 42 CFR 438.6(e) services. In order to provide a service to its Medicaid beneficiaries, the State must have authority under its State Plan or through a waiver such as the 1915(b)(3) waiver. 1915(c) and 1115 Demonstration waivers also have authority for the provision of services outside of the Medicaid State Plan. CMS will match managed care expenditures for services under the State Plan or approved through an approved waiver. The State cannot mandate the provision of services outside of its State Plan or a waiver.

Initial waivers must estimate the amount of savings from fee-for-service that will be expended upon 1915(b)(3) services in the initial waiver. The State must document that the savings in state plan services, such as reductions of utilization in hospital and physician services, are enough to pay for the projected 1915(b)(3) services. If the State contends that there is additional state plan savings generated from the (b)(3) services those can only be documented after the State has documented that state plan-generated savings are enough to pay for the 1915(b)(3) Costs. Trend for 1915(b)(3) services in the initial waiver can be no greater than State Plan service trend (because there is no historic 1915(b)(3) service trend rate) as noted in the adjustments section.

The State must separately document Medical Assistance service expenditures and State administrative costs related to those services. Case management fees paid to providers in a PCCM program should be included as Medical Assistance service expenditures.

A State may make changes to their Medicaid and/or Medicaid waiver programs (e.g., changes to covered services or eligibility groups) during the period of time covered by an existing waiver. When the State makes these changes and there is a cost impact, CMS will require States to submit amendments which will modify P1 and P2 of the existing waiver calculations. By amending the existing P1 and P2 the State will ensure that when the State does its subsequent Renewal Waiver the R1 and R2 actual expenditures do not exceed the previous waiver's P1 and P2 expenditures solely as a result of the change to the Medicaid and/or Medicaid waiver program.

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

**Step 2.** List the BY eligible member months (R2 if a renewal). *See the example spreadsheets.*

**Step 3.** List the weighted average PMPM calculated in Appendix D3 for Initial, Conversion or Comprehensive Renewal waivers.

Expedited Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D. To calculate the PMPM by MEG, the State should divide the cost from Schedule D for R2 and by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts.

**Step 4.** In **Appendix D5**, list the program adjustments percentages and the monetary size of the adjustment by MEG as applicable for State Plan services. The State may then combine all adjustment factors which affect a given MEG, and apply the adjustments accordingly. The derivation of a combined adjustment factor must be explained and documented.

Note adjustments in different formats as necessary. *See the Nebraska example spreadsheet as an example only. Some adjustments may be additive and others may be multiplicative. Please use the appropriate formula for the State's method.*

**Step 5.** Compute the PMPM projection by MEG by adding the service, incentive, administration, and 1915(b)(3) costs and the effect of all adjustments. These amounts need to be reflected in the State's next waiver renewal. These amounts represent the final PMPM amounts that will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes among MEGs when submitting their next waiver renewal cost-effectiveness calculations. In the

subsequent renewal, the State should have PMPM Actual Waiver costs for each MEG for the 2-year period equal to or less than these Projected PMPM Waiver Costs for each MEG.

**Appendix D6 – RO Targets**

For the purpose of on-going quarterly monitoring in the future period, the State must document total cost and PMPM cost projections for RO use. The ROs will be using a two-fold test: one that monitors for overall growth in waiver costs on the CMS-64 forms and another that monitors for PMPM waiver cost-effectiveness. The State projections for RO use in both tests are in Appendix D6.

The first test projects quarterly aggregate expenditures by MEG for RO use in monitoring CMS 64.9 Waiver, CMS 64.21U Waiver, and CMS 64.10 Waiver expenditures during the upcoming waiver period. On a quarterly basis, CMS will compare aggregate expenditures reported by the State on CMS-64 Waiver forms to the State's projected expenditures (P1 and P2) included in the State's cost-effectiveness calculations as a part of the quarterly CMS-64 certification process. As part of the waiver submission, the State must calculate and document the projected quarterly aggregate Medical Assistance services and State administrative expenditures for the upcoming period. This projection is for the population covered under the waiver and will assist RO financial staff in monitoring the total waiver spending on an on-going basis.

The second test projects quarterly PMPM expenditures by MEG for RO use in monitoring waiver cost-effectiveness in the future waiver period. Because states are required to demonstrate cost-effectiveness in the historical two-year period of each Renewal Waiver, CMS intends to monitor State expenditures on an ongoing basis using the State's CMS-64 Waiver submissions. CMS will determine if the State's quarterly CMS-64 Waiver submissions support the State's ability to demonstrate cost-effectiveness when the State performs its Renewal Waiver calculations. For the second test, States are not held accountable for caseload increases. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State must submit member month data corresponding to the quarterly submission of the CMS-64 on an on-going basis. The State should ensure that the member month data submitted on an on-going basis is comparable to the member month data used to prepare the P1 and P2 member month projections. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter.

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months**.

**Step 2.** List the P1 and P2 projected member months by quarter for the future period.

**Step 3.** List the P1 and P2 MEG PMPM cost projections from **Appendix D5**. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State will calculate the weighted average PMPM with Casemix for P1 and P2 (respectively).

| Renewal P1 | Renewal P2 |
|---|---|
| $\frac{\text{P1 PMPM Costs x P1 MM}}{\text{P1 MM}}$ | $\frac{\text{P2 PMPM Costs x P2 MM}}{\text{P2 MM}}$ |
| Casemix for P1 | Casemix for P2 |

The State is calculating the PMPM with Casemix for P1 and P2 so that the Region can compare the projected PMPMs to the actual PMPMs for administration (the State is calculating all of the PMPMs but only the administration PMPM will be used in Appendix D6). Administration is an area of risk for States in a 1915(b) waiver. If a State does not enroll enough persons into the program to offset high fixed administration costs, the State is at risk for not being cost-effective over the two year period. The Region will use this particular weighted PMPM to monitor State enrollment levels to ensure that high administrative costs are more than offset on an on-going basis.

**Step 4.** Multiply the quarterly member month projections by the P1 and P2 PMPM projections to obtain quarterly waiver aggregate targets for the waiver. *See the example spreadsheets.*

For the first aggregate spending test, the State will use the MEG PMPM from Appendix D5 multiplied by the projected member months to obtain the aggregate spending. The MEG PMPM from Appendix D5 is the number that States will be held accountable to in their waiver renewal. However, States will not be held accountable to the projected member months in their waiver renewal. For this reason, a second test modifying the demographics to reflect actual caseload is necessary.

| | | **Total PMPM** | **Q1 Quarterly Projected Costs** | | |
|---|---|---|---|---|---|
| **Medicaid Eligibility Group (MEG)** | **Total PMPM Administration Cost Projection** | **Projected Service Costs** | **Member Months Projections** | **64.9W /64.21U W Service Costs include incentives** | **64.10 Waiver Administration Costs** |
| MCHIP - MCO/PCCM/PIHP (3 co.) | $ 10.00 | $ 192.90 | 81 | $ 15,624.75 | $ 810.39 |
| MCHIP - PIHP statewide | $ 0.86 | $ 21.20 | 28,821 | $ 611,004.39 | $ 24,866.56 |
| Title XIX MCO/PCCM/PIHP (3 co) | $ 47.33 | $ 954.89 | 15,981 | $ 15,260,090.40 | $ 756,396.07 |

| | | | | | |
|---|---|---|---|---|---|
| Title XIX - PIHP statewide | $ 2.37 | $ 48.20 | 444,217 | $ 21,409,496.79 | $ 1,051,238.55 |
| **Total** | | | **489,100** | **$ 37,296,216.33** | **$ 1,833,311.56** |
| **Weighted Average PMPM Casemix for P1 (P1 MMs)** | **$ 3.77** | | | | |

**Step 5.** Create a separate page that documents by quarter Form 64.9 Waiver, Form 64.21U Waiver, and Form 64.10 Waiver costs separately for ease of RO CMS-64 monitoring. *See the example spreadsheets.*

Example:

Projected Year 1 - July 1, 2002 - June 30, 2003

| Waiver Form | Medicaid Eligibility Group (MEG) | Q1 Quarterly Projected Costs Start 7/1/2002 |
|---|---|---|
| **64.21U Waiver Form** | MCHIP - MCO/PCCM/PIHP (3 co) | $ 15,624.75 |
| **64.21U Waiver Form** | MCHIP - PIHP statewide | $ 611,004.39 |
| **64.9 Waiver Form** | Title XIX - MCO/PCCM/PIHP (3 co) | $ 15,260,090.40 |
| **64.9 Waiver Form** | Title XIX - PIHP statewide | $ 21,409,496.79 |
| **64.10 Waiver Form** | All MEGS | $ 1,833,311.56 |

**Step 6.** Create a separate page that documents by quarter PMPM MEG costs separately for each of RO monitoring. Please include space for RO staff to list actual member months and aggregate totals by quarter. Please include formulas for RO staff to calculate actual PMPMs by quarter for comparison to projections. *See the example spreadsheets.*

For the second test, the State will carry forward the P1 (and P2 respectively) MEG PMPM services costs and the weighted average PMPM administration costs Casemix for P1 (and P2 respectively).

Divide the actual aggregate costs by the actual aggregate member months (MM) to get PMPM actual costs**.** The State will divide the costs of the program by the caseload for the same quarter from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each quarter of the waiver. In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

| On-going Actual P1 Q1 | On-going Actual P2 Q5 |
|---|---|
| P1 Q1 Actual Costs / P1 Q1 Actual MM | P2 Q5 Actual Costs / P2 Q5 Actual MM |
| Casemix for P1 Q1 actual | Casemix for P2 Q5 actual |

On an on-going basis, the State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms. The RO analyst will enter the member month and CMS-64 form totals into the worksheet, which will calculate the actual MEG PMPM costs. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected PMPM expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions.

Example

| **Waiver Form** | **Medicaid Eligibility Group (MEG)** | **State Completion Section - For Waiver Submission** | **RO Completion Section - For ongoing monitoring** | | |
|---|---|---|---|---|---|
| | | | **Q1 Quarterly Actual Costs** | | |
| | | **P1 Projected PMPM From Column I (services) From Column G (Administration)** | **Member Months Actuals Start 7/1/2002** | **Actual Aggregate Waiver Form Costs** | **Actual PMPM Costs** |
| **64.21U Waiver Form** | MCHIP - MCO/PCCM/PIHP (3 co.) | **$ 192.90** | | | #DIV/0! |
| **64.21U Waiver Form** | MCHIP - PIHP statewide | **$ 21.20** | | | #DIV/0! |
| **64.9 Waiver Form** | Title XIX - MCO/PCCM/PIHP (3 co) | **$ 954.89** | | | #DIV/0! |
| **64.9 Waiver Form** | Title XIX - PIHP statewide | **$ 48.20** | | | #DIV/0! |
| **64.10 Waiver Form** | All MEGS | **$ 3.77** | | | #DIV/0! |

**Appendix D7 - Summary**
Document the State's overall cost-effectiveness analysis by waiver year.

In a renewal analysis, the State must clearly demonstrate that the PMPM actual waiver expenditures did not exceed the projected PMPM waiver expenditures for the population covered by the waiver. *For example, suppose a State's Initial Waiver (ST 01) considered years 2003 and 2004 to be P1 and P2 respectively. In the subsequent Renewal Waiver (ST 01.R01), the State's R1 and R2 will also be years 2003 and 2004, respectively. The State must demonstrate that in total the actual expenditures in the current Renewal Waiver's R1 and R2 (2003 and 2004) did not exceed the total projected expenditures in the Initial Waiver's P1 and P2 (2003 and 2004). Taking the example above, a State would use the actual expenditures from 2003 and 2004 as the basis for projecting expenditures for the renewal waiver period 2005-2006 (P1 and P2 respectively). In the second Renewal Waiver (ST 01.R02), the actual expenditures in the renewal period for 2005-2006 (R1 and R2) must be less than the expenditures for 2005-2006 (P1 and P2) projected in the previous renewal (ST 01.R01). For each subsequent renewal, the State will compare actual expenditures in R1 and R2 to the projected P1 and P2 values from the previously submitted Renewal Waiver.*

Cost-effectiveness will be determined based on the sum of Medical Assistance service expenditures and State administrative costs on a PMPM for the two-year period. In this instance, the weighted PMPM for both the projection and the actual cost is based on the Casemix for actual enrollment in R1 and R2. In this way, the State is not held accountable for any caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

**Step 2.** List the BY (R1 and R2 if a renewal), P1 and P2 annual projected member months.

**Step 3.** List the BY (R1 and R2 if a renewal), P1 and P2 PMPM projections from **Appendix D5**.

List and calculate the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the PMPM for that year's demographics and for the previous year's demographics so that CMS can compare the PMPM for the enrolled caseload to the PMPM holding the caseload's demographics constant. In short, the new PMPM times the old MM (new dollars times old weights = Casemix effect for old MM) is the Casemix for the old MM.

Initial or Conversion Waiver

| Year | Calculation | Where Already Calculated | Formula |
|---|---|---|---|

| | | | |
|---|---|---|---|
| BY | BY Overall PMPM for BY (BY MMs) | Appendix D3 | $\frac{\text{BY Aggregate Costs}}{\text{BY MM}}$ |
| P1 | P1 Weighted Average PMPM Casemix for BY (BY MMs)<br>P1 Weighted Average PMPM Casemix for P1 (P1 MMs) | <br>Appendix D6 | $\frac{\text{P1 PMPM x BY MM}}{\text{BY MM}}$<br>$\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$ |
| P2 | P2 Weighted Average PMPM Casemix for P1 (P1 MMs)<br>P2 Weighted Average PMPM Casemix for P2 (P2 MMs)<br>P2 Weighted Average PMPM Casemix for BY (BY MMs)<br>P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | <br>Appendix D6<br><br>Appendix D6 | $\frac{\text{P2 PMPM x P1 MM}}{\text{P1 MM}}$<br>$\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$<br>$\frac{\text{P2 PMPM x BY MM}}{\text{BY MM}}$<br>$\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$ |

Renewal Waiver

| Year | Calculation | Where Already Calculated | Formula |
|---|---|---|---|
| R1 | R1 Overall PMPM for R1 (R1 MMs) | Appendix D3 | $\frac{\text{R1 Aggregate Costs}}{\text{R1 MM}}$ |
| R2 | R2 Weighted Average PMPM Casemix for R1 (R1 MMs)<br>R2 Overall PMPM for R2 (R2 MMs) | <br>Appendix D3 | $\frac{\text{R2 PMPM x R1 MM}}{\text{R1 MM}}$<br>$\frac{\text{R2 Aggregate Costs}}{\text{R2 MM}}$ |
| P1 | P1 Weighted Average PMPM Casemix for R2 (R2 MMs)<br>P1 Weighted Average PMPM Casemix for P1 (P1 MMs) | <br>Appendix D6 | $\frac{\text{P1 PMPM x R2 MM}}{\text{R2 MM}}$<br>$\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$ |
| P2 | P2 Weighted Average PMPM Casemix for P1 (P1 MMs)<br>P2 Weighted Average PMPM Casemix for P2 (P2 MMs)<br>P2 Weighted Average PMPM Casemix for R1 (R1 MMs)<br>P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | <br>Appendix D6<br><br>Appendix D6 | $\frac{\text{P2 PMPM x P1 MM}}{\text{P1 MM}}$<br>$\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$<br>$\frac{\text{P2 PMPM x R1 MM}}{\text{R1 MM}}$<br>$\frac{\text{P2 PMPM x P2 MM}}{\text{P2 MM}}$ |

**Step 4.** Calculate a total cost per waiver year. Multiply BY MM by BY PMPM. (Renewal Waiver, multiply R1 MM by R1 PMPM and multiply R2 MM by R2 PMPM) Multiply P1 MM by P1 PMPM. Multiply P2 MM by P2 PMPM. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application.*

**Step 5.** Renewal Waiver only - Calculate the Total Previous Waiver Period

Expenditures (Casemix for R1 and R2). *Note: the Total Cost per Waiver for R1 should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application.*

**Step 6.** Calculate the Total Projected Waiver Expenditures for P1 and P2.

**Step 7.** Calculate the annual percentage change. For Initial and Conversion waivers, calculate the percentage change from BY to P1, P1 to P2 and BY to P2 for each MEG. For renewals, calculate the percentage change from R1 to R2, R2 to P1, P1 to P2, and R1 to P2 for each MEG. Calculate the annual percentage change for the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the annual percentage change in the PMPM compared to the previous year for that year's demographics and for the previous year's demographics. This allows CMS to compare the percentage of the PMPM that changed due to the caseload's demographics changes. The sample spreadsheets have appropriate formulas for State use. Explain these percentage changes in the State Completion section.

**Step 8.** Renewal Waiver only - list the PMPM cost projections (P1 and P2) by MEG from the previous waiver submittal.

**Step 9.** Renewal Waiver only - Calculate the Actual Previous Waiver Period Expenditures, Total Projection of Previous Waiver Period Expenditures, and Total Difference between Projections and Actual Waiver Cost for the Previous Waiver using actual R1 and R2 member months. Using actual R1 and R2 member months will hold the State harmless for caseload changes. Multiply the PMPM projections by the actual R1 and R2 member months to obtain the overall expenditures for the past Waiver Period. Subtract waiver actual waiver costs for R1 and R2 from the projected PMPM program costs previously submitted (P1 and P2 in the previous waiver submission) to obtain the difference between the Projections and Actual Waiver Cost for the retrospective period. If **Actual Waiver Service Cost plus the Actual Waiver Administration Cost is less than or equal to Projected Waiver Cost,** then the State has met the Cost-effectiveness test and the waiver may be renewed.

## IV. State Completion Section

### A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

**b.** Name of Medicaid Financial Officer making these assurances: **Tom Suehs, HHSC-CFO**

c. Telephone Number: **(512) 424-6526**

**B. For Renewal Waivers only - Expedited or Comprehensive Test**—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.**_X_** Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive*

*waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

**C. Capitated portion of the waiver only: Type of Capitated Contract**

The response to this question should be the same as in **A.III.a**.

a.___ Risk-comprehensive (fully-capitated--MCOs, HIOs)
b._X_ Partial risk/ PIHP
c.___ Partial risk/ PAHP
d.___ Other (please explain):

**D. PCCM portion of the waiver only: Reimbursement of PCCM Providers**

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe). Responses must match those provided in **Section A.IV.C.4 (PCCM-only preprint – n/a in capitated-only preprint)**:

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  1.___ First Year: $____ per member per month fee
  2.___ Second Year: $____ per member per month fee
  3.___ Third Year: $____ per member per month fee
  4.___ Fourth Year: $____ per member per month fee
b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.IV.I**.d.2, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to

savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. Response can be included in

d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

**E. Appendix D1 – Member Months**

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data

1.___ Base year data is from the same population as to be included in the waiver.

2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

_____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

_____

For Conversion or Renewal Waivers:

a._X_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State estimated up to six (6) months of enrollment data for R2 of the previous waiver period. Note the length of time estimated:

_____

c._X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

**The members months projected reflect Medicaid population projections in the Dallas area. The major increase occurs in the TANF child population. The increase is related to the simplification of the eligibility process generated by SB 43 from the last legislative session and the downturn in the economy.**

d. ___ [Required] Explain any other variance in eligible member months from BY/R1 to P2: ____

e.__X_[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.
**The base year in the waiver application is the regional office approved period of the calendar year January 1, 2002 through December 31, 2002, because that period most closely demonstrates current activity, and it begins at a federal fiscal quarter beginning.**

## F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:
**The service array is this conversion renewal is the same as previous waiver submissions**

b._X_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account:
**No BH services from the state plan or the previous waiver periods are excluded. The state plan pharmacy services in the Dallas area are covered under a separate program addressed in the STAR waiver. This waiver and the STAR waiver both cover the Medicaid population in the Dallas area, but each program collects its own costs and contracts with separate entities for separate services.**

## G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. The allocation method is explained below:

a.___The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c._**X**_ Other (Please explain).

**The NorthSTAR Behavioral Health 1915(b) waiver has no fee-for-service component, so administration is allocated between MEGs based on member months.**

## H. Appendix D3 – Actual Waiver Cost

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.b** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

**Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections**

| 1915(b)(3) Service | Savings projected in State Plan Services | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|---|---|
| *(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)* | *$54,264 savings or .03 PMPM* | *9.97% or $5,411* | *$59,675 or .03 PMPM P1*<br><br>*$62,488 or .03 PMPM P2* |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| Total | *(PMPM in Appendix D5 Column T x projected member months should correspond)* | | (PMPM in Appendix D5 Column W x projected member months should correspond) |

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

**Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections**

| 1915(b)(3) Service | Amount Spent in Retrospective Period | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|---|---|
| *(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)* | *$1,751,500 or $.97 PMPM R1*<br><br>*$1,959,150 or $1.04 PMPM R2 or BY in Conversion* | *8.6% or $169,245* | *$2,128,395 or 1.07 PMPM in P1*<br><br>*$2,291,216 or 1.10 PMPM in P2* |
| | | | |
| | | | |
| | | | |
| **Total** | (PMPM in Appendix D3 Column H x member months should correspond) | | (PMPM in Appendix D5 Column W x projected member months should |

| | | | |
|---|---|---|---|
| | | | correspond) |

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c.___ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d.____Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.IV.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.IV.I.e and D.IV.J.f)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

## I. Appendix D4 – Adjustments in the Projection

**Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver , skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments):** States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in **Appendix D5**.

**The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.**

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend

rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the

State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*.
Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved

SPA. PMPM size of adjustment _____

D.____ Other (please describe):

v.__ Other (please describe):

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____ Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the

State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.IV.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.IV.I.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.IV.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.IV.G.d.2**, then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

**1.** List the State Plan trend rate by MEG from **Section D.IV.I.a**._____

**2.** List the Incentive trend rate by MEG if different from **Section D.IV.I.a** _____

**3.** Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

*Method:*

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine GME adjustment based on a pending SPA.

3.___ Determine GME adjustment based on currently approved GME SPA.

4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

*Basis and Method*:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

*Method:*

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL)* Adjustment**: This adjustment should be used only if the State will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

*Basis and method:*

1.___ No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.*
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
   i.___Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

*For Combination Capitated and PCCM Waivers: If the MCO/PIHP/PAHP will collect and keep TPL recoveries, then the PCCM Actual Waiver Cost must be calculated less the TPL recovery amount expected in the PCCM program. For

additional information, please see Special Note at end of this section.

j. **Pharmacy Rebate Factor Adjustment ***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population.* Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS.

3.___ Other (please describe):

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of rebate collections, then the PCCM Actual Waiver Cost must be calculated less the pharmacy rebate amount expected in the PCCM program. For additional information, please see Special Note at end of this section.

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with

voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

**Special Note section:**

**Waiver Cost Projection Reporting: Special note for new capitated programs**
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

**Special Note for initial combined waivers (Capitated and PCCM) only:**
**Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations --** Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a**

**single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The three most common offsetting adjustments that will be needed are noted in the chart below and indicated with an asterisk (*) in the preprint.

| Adjustment | Capitated Program | PCCM Program |
|---|---|---|
| Administrative Adjustment | The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column) | The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness). |
| Third-Party Liability Adjustment | The MCO will collect and keep TPL recoveries. The Capitated Waiver Cost Projection is created less the Third-Party Liability amount. That adjustment is subtracted from the combined Waiver Cost Projection adjustment. | The PCCM Actual Waiver Costs must be calculated less the TPL recovery amount expected in the PCCM program. |
| Pharmacy Rebate Adjustment | The Capitated Waiver Cost Projection is created less the pharmacy rebate amount. That adjustment is subtracted from the combined Waiver Cost Projection adjustment. | The PCCM Actual Waiver Costs must be calculated less the pharmacy rebate amount expected in the PCCM program. |

n. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must

adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

  1.___ No adjustment was made.
  2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

**J. Conversion or Renewal Waiver Cost Projection and Adjustments.**
**If this is an Initial waiver submission, skip this section:** States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are

calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2._X_ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. _X_ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used.

**National CPI-U and CPI-Medical inflation rates were applied to categories of service in the same method as previous waivers PMPMs were calculated, generating composite inflation factors to be applied to the base year PMPM for prospective year one, and to P1 for P2. The schedule was included as a new schedule D5A. Cost Inflation Calculation after schedule D5. Waiver Cost Projection.**

In addition, please indicate how this factor was determined to be predictive of this waiver's future costs.

**This method is a continuation of the methodology used to calculate the next two waiver year's rates in the rate setting methodology.**

Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

**No other factors were considered.**

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver

separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA*. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1._X_ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

vi.__ Other (please describe):

A.____ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____ Other (please describe):

c.___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2._X_ An administrative adjustment was made.

i.___Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii._X__Cost increases were accounted for.

A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C._X_Other (please describe):

**Percentage changes were calculated between actual expended administrative costs for the base year and estimated administrative costs for the waiver years based on proposed operating budgets for the agency. Additional activities budgeted are for actuarial certification of our data and rate setting methodologies, and BBA compliance that were not budgeted or expended in the base year.**

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than

a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.IV.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.IV.J.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.IV.J.a**. above _____.

**e. Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

**1.** List the State Plan trend rate by MEG from **Section D.IV.J.a** _____

**2.** List the Incentive trend rate by MEG if different from **Section D.IV.J.a**.

_____

**3.** Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please Describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no

longer match excess institutional UPL payments.

- Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1_**X**_No adjustment was made.
2.___This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

**K. Appendix D5 – Waiver Cost Projection**

The State should complete these appendices and include explanations of all adjustments in **Section D.IV.I and D.IV.J** above.

**L. Appendix D6 – RO Targets**

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.IV.E.** above.

**M. Appendix D7 - Summary**

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
   1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.IV.E. c & d**:
      **The members months projected reflect Medicaid population projections in the Dallas area. The major increase occurs in the TANF child population. The increase is related to the simplification of the eligibility process generated by SB 43 from the last legislative session and the downturn in the economy.**

   2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.IV.I and D.IV.J**:
      **National CPI-U and CPI-Medical inflation rates were applied to categories of service in the same method as previous waivers PMPMs were calculated, generating composite inflation factors to be applied to the base year PMPM for prospective year one, and to P1 for P2. The schedule was included as a new**

**schedule D5A. Cost Inflation Calculation after schedule D5. Waiver Cost Projection. No other factors were considered in the cost calculation.**

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.IV.I and D.IV.J**:

**No utilization factors were considered in the calculation of cost increases.**

**4.** Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

**Section E. FRAUD AND ABUSE**

States must promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PIHPs/PAHPs have certain provisions in place.

**Previous Waiver Period**

**a._X_** [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period. [Reference: items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint, item E.I Upcoming Waiver Period, 1999 Waiver Renewal Preprint)]

**The State's contract with the BHO requires that they report any suspected fraud and abuse on the part of enrollees or providers. In addition, the BHO is required to submit a Fraud and Abuse compliance plan, which is reviewed and approved by the State. The State has also required the BHO to comply with the US office of the Inspector General's model fraud and abuse compliance plan.**

**To assist the BHO, the State has held workshops and worked directly with the BHO to help ensure that existing plans and systems are adequate.**

**The State also actively reviews claims information in pre-identified high risk areas to identify any trends or patterns that might indicate that abusive or fraudulent billing practices are present. In one instance a provider was identified who was inappropriately billing the BHO for services. The provider is no longer in the BHO network and the provider was referred to the State's Medicaid Fraud Control Unit for additional investigation and sanctions.**

**Upcoming Waiver Period** -- Please check all items below which apply, and describe any other measures the State takes.

**I. State Mechanisms**

**a._**X_ The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PIHP/PAHP, by the State's claims processing system).

**b.___** The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

**c.**_X_ The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to this effort. Please attach the fraud and abuse plan.

**The State requires the BHO to adopt a fraud and abuse plan required by the Texas Health and Human Services Commission (HHSC). The HHSC plan is modeled after the plan distributed by the US Office of Inspector General. The approved BHO Fraud and Abuse Plan is Attachment # 9.**

**d.**_X_ The State has a specific process for informing MCOs/PIHPs/PAHPs of fraud and abuse requirements under this waiver. If so, please describe.

**The State has developed and implemented specific training for managed care organizations pertaining to fraud and abuse. Both NorthSTAR BHOs participated in this training during the first waiver cycle. Additionally, the State has incorporated specific provision into the BHO contract that mandates that the BHO develop and submit to the State a fraud and abuse compliance plan. Furthermore, the State has incorporated a specific provision within the contract that requires the BHO to allow the Texas Medicaid Fraud Control Unit to conduct private interviews of Contractor's and its subcontractors' employees, witnesses and Enrollees. The BHO must also comply with requests for information in the form and the language requested. The BHO and its subcontractors' employees are further required to cooperate fully and be available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other fraud and abuse investigation processes at the BHO's and subcontractor's own expense.**

**e.___** Other (please describe):

## II. MCO/PIHP/PAHP Fraud Provisions

**a._ _** [Required for MCOs/PIHPs if State payments based on data submitted by MCO/PIHP, e.g. encounter data] MCO/PIHP must certify data as follows:

**NorthSTAR payments to the BHO are based on enrollment.**

(i) data is accurate, complete, and truthful based on best knowledge, information, and belief
(ii) certification is made by plan CEO, CFO, or individual delegated to sign for, and reports to, plan CEO or CFO
(iii) certification is submitted concurrently with data

b.__X_[Required for MCO/PIHPs]The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Plan includes:
(i)_X_Written polices that articulate commitment to comply with all applicable Federal and State laws
(ii)_X_Designation of compliance officer and committee
(iii)_X_Effective training and education for compliance officer and plan employees
(iv)_X_Enforcement of standards through well-publicized disciplinary guidelines
(v)_X_Provision for internal monitoring and auditing
(vi) _X_Provision for prompt response to detected offence, and corrective action initiative related to MCO/PIHP contract

c. _X_ [Required for MCOs/PIHPs/PAHPs] The plan is prohibited from having affiliations with an individual who is, or who is affiliated with, an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.

d. _X_ The State requires MCOs/PIHPs/PAHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.

**Section F. SPECIAL POPULATIONS**

States may wish to refer to the October 1998 CMS document entitled "Key Approaches To The Use of Managed Care Systems For Persons With Special Health Care Needs" as guidance for efforts to ensure access and availability of services for persons with special needs. To a certain extent, key elements of that guide have been incorporated into this waiver application form.

## I. General Provisions for Special Populations

### Previous Waiver Period

**a.**_X_ [Required for all elements of applicable sections checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.I.a-g of the 1999 initial preprint; as applicable in 1995 preprint, item F.I. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].

**Please note that NorthSTAR is a specialty carve out and as such directly focuses on a specialized set of services that address the behavioral health needs of individuals – regardless of placement into other particular subsets or "special needs" categories.**

**The State has worked directly with the BHO as well as with STAR MCOs to develop an infrastructure for the coordination of physical and behavioral health care for individuals with co-occurring physical and behavioral health needs.**

**Additionally, the State has monitored all complaints to ensure that any issues related to any individual with special needs is addressed promptly and appropriately and to identify any patterns or trends affecting services for special populations that would require a systems-based response. The BHO performed well during the previous waiver cycle. No patterns or trends have been identified in the complaint data indicating that Medicaid eligible disabled adults, children or adoption subsidy children are having difficulty in accessing the full range of NorthSTAR services. In fact, the total number of complaints related in any way to Medicaid children has averaged 2.3 complaints per month for the Waiver period 11/01 through 4/03. Any complaints that have arisen have generally been addressed appropriately and in a timely manner by the BHO.**

**While not specific to a particular sub-population, the State and the BHO through the EQRO monitoring process have identified a need to**

**continue to refine and improve care coordination between the physical health (STAR) and behavioral health (NorthSTAR) systems of care. To that end, the State is working with the BHO to incorporate the need for tighter coordination into the BHO's Quality Improvement operations and the BHO is working to implement follow up improvement initiatives in this area. These include:**

**1. The interagency care coordination workgroup meets at least quarterly and includes representatives from the STAR (MCO) program and the BHO, with facilitation provided by the State's quality manager. This group works cooperatively to comply with the guidelines of their 1999 Memorandum of Agreement, which calls for working together to resolve currently identified coordination issues, and to identify and resolve other issues as they arise. An emphasis is placed on developing procedures for effective and timely communication between MCO's and the BHO. The group also strives to develop protocols and processes for coordination of care, including coordination of services for special needs populations and individuals whose symptoms might pose a barrier to standard care coordination.**

**2. The BHO has assigned the Clinical Director as the primary staff to work with the care manager work group in order to ensure that facilitating communication is a part of routine operations.**

**3. The BHO care managers are now routinely seeking information related to PCP assignment and enter that information into the BHO system.**

**4. Procedures have been adapted to ensure that all medical record reviews will include items related to the coordination of physical and behavioral health care.**

**b.** Please describe the transition plan for situations where an enrollee with special health care needs will be assigned to a new provider when the current provider is not included in the provider network under the waiver.

**NorthSTAR has been fully operational since November of 1999. Individuals who were seeing non-network providers prior to the implementation of NorthSTAR have already been transitioned into the BHO's network. There are three instances in which an individual may be transferred from a non-network provider into the NorthSTAR system:**

**1. When an individual first gains Medicaid eligibility**

**2. When a Medicaid-eligible individual who is in a category excluded from enrollment in NorthSTAR moves into a category served by NorthSTAR (e.g. a child in State protective foster care returns to his/her natural family).**

**3. When an individual who is already eligible for Medicaid moves into the service region from another service area.**

**It is noteworthy that since November 1999, NorthSTAR has seen a significant expansion of the provider network. This expansion has increased the likelihood that individuals first entering the system will be able to continue to receive services from their previous provider.**

**Additionally, since NorthSTAR serves both Medicaid eligible and medically indigent individuals, in many instances individuals are already being served in NorthSTAR when they gain Medicaid eligibility eliminating the need to change providers as Medicaid eligibility is gained (or lost).**

**To ensure smooth transition for children transitioning into (or out of) protective foster care, the State has required the BHO to designate a full-time liaison to work with the regional TDPRS staff to address:**

- **how the BHO and the Texas Department of Protective and Regulatory Services (TDPRS) coordinate care and services**
- **the exchange of behavioral health information on Enrollees; and**
- **reporting requirements from the BHO to TDPRS.**

**Additionally, NorthSTAR staff has provided, and will continue to provide, direct coordination with TDPRS to ensure coordination for children going into or coming out of protective foster care.**

**In all instances, the BHO is required to implement policies and procedures to ensure effective information sharing and monitoring of diagnosis, treatment, follow-up and medication usage between providers and other health care plans.**

**Upcoming Waiver Period** -- Please check all items that apply to the State.

**a.**_X_ The State has a specific definition of "special populations" or "populations with special health care needs." The definition should include populations beyond those who are SSI or SSI-related, if appropriate, such as persons with serious and persistent mental illness, and should specify whether they include adults and/or children. Some examples include: Children with special needs due to physical and/ or mental illnesses, Older adults (over 65), Foster

care children, Homeless individuals, Individuals with serious and persistent mental illness and/or substance abuse, Non-elderly adults who are disabled or chronically ill with developmental or physical disability, or other. Please describe.

**The State has a definition of <u>children</u> with special needs that includes children who are:**

1. **Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI)**
2. **Eligible under Section 1902(e)(3) of the Social Security Act**
3. **In foster care or other out-of-home placement**
4. **Receiving foster care or adoption assistance**
5. **Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as is defined by the State in terms of either program participant or special health care needs**

**b.**_X_ There are special populations included in this waiver program. Please list the populations.

**While not included within an official State definition, NorthSTAR serves individuals with mental illness and/or chemical dependency. As a behavioral health specialty "carve out", NorthSTAR has as its primary focus the delivery of specialized services to this population.**

**Within this specialty population, NorthSTAR serves a number of sub-populations including blind/disabled children and related populations, children receiving adoption assistance, and disabled adults. NorthSTAR does <u>not</u> serve individuals eligible under Section 1902(e)(3) of the Social Security Act, children residing in ICF-MR or nursing facilities, children receiving services through Title V grants or children in protective foster care.**

**c.**_X_ The State has developed and implemented processes to collaborate and coordinate with, on an ongoing basis, agencies that serve special needs clients, advocates for special needs populations, special needs beneficiaries and their families. If checked, please briefly describe.

**The State has included the existing system of Community Resource Coordination Groups (CRCGs) into the design of NorthSTAR. CRCGs address the issue of coordinated service planning and include representatives from the Texas Department of Protective and Regulatory Services (TDPRS), the Texas Commission for the Blind (TCB), the Texas Department of Health (TDH) which is the Title V agency, the Texas Department of Human Services (TDHS), the Texas Department of Mental Health and Mental Retardation (TXMHMR), the Texas Education Agency (TEA), the Texas Interagency Council on Early Childhood**

**Intervention (ECI), the Texas Juvenile Probation Commission (TJPC), the Texas Rehabilitation Commission (TRC), the Texas Commission on Alcohol and Drug Abuse, and the Texas Youth Commission (TYC). These agency representatives, as well as representatives from a number of other private and public agencies, come together to develop individualized coordinated service plans for children and adolescents whose needs can be met only through interagency coordination and cooperation.**

**The CRCG team meets regularly (as often as twice per month) to address the service coordination needs of individual children and adolescents who are involved with, or receiving services from, multiple agencies. To assure a comprehensive and coordinated approach to treatment for children enrolled in NorthSTAR, the State mandates that the BHO enter into a written agreement with the local CRCG for service planning.**

**d.**_X_ The State has programs/services in place which coordinate and offer additional resources and processes to ensure coordination of care among:

1.___ Other systems of care (Please specify, e.g. Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds)

2.___ State/local funding sources

3._X_ Other (please describe):

**Community Resource Coordination Groups (CRCGs) are local interagency groups composed of representatives from public and private agencies that develop service plans for children and adolescents whose needs can be met only through interagency coordination and cooperation.**

**CRCGs originated when the Texas Legislature passed Senate Bill 298 into law in 1987. This bill directed the state agencies serving children to develop a community-based approach to provide better coordination of services for children and youth who have multi-agency needs and require interagency coordination. Pursuant to this legislation, numerous state agencies have entered into an agreement to provide for the implementation of a system of CRCGs that have as their primary function the coordination of services for children and youths who need services from more than one agency.**

**e.**_X_ The State has in place a process for ongoing monitoring of its listed special populations by special needs subpopulation included in the

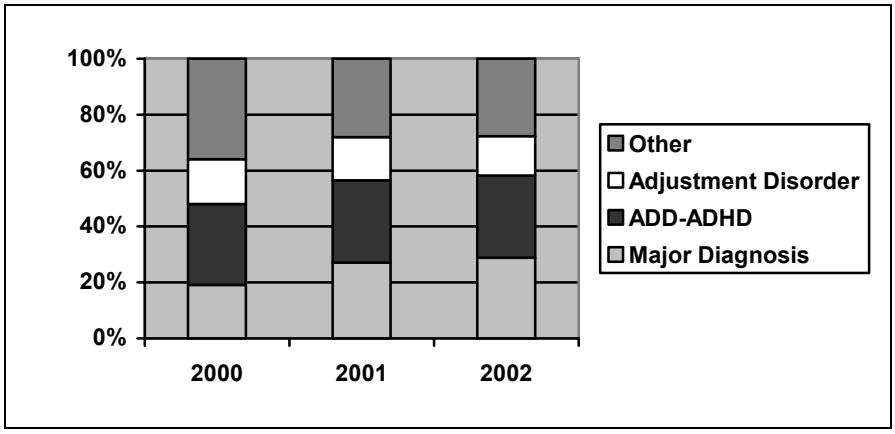
waiver in the following areas:

1._X_ Access to services (please describe):
2._X_ Quality of Care (please describe):
3._X_ Coordination of care (please describe):
4.___ Enrollee satisfaction (please describe):
5.___ Other (please describe):

**NorthSTAR has as its primary focus the delivery of specialized behavioral health services to individuals with mental illness or chemical dependency. In addition to this primary specialty population, NorthSTAR has placed additional emphasis on two specific Medicaid sub-populations - pregnant women and children (including adolescents).**

**The State specifically tracks complaint data for each of these two sub-populations and has also targeted both of these populations in separate focused studies (one focusing on children with ADHD and one focusing on pregnant women with chemical dependency) with a view toward improving quality of care and care coordination for these two groups. The State requested that the BHO perform follow-ups to these two studies, which are attached to this document.**

**Furthermore, the state has performed an analysis comparing services delivered to children under NorthSTAR during FY 2000, FY 2001, and FY 2002. This analysis indicates that NorthSTAR continues to be successful in targeting services to children most in need. This data is reflected in the below chart.**




Percent of Children's Services by Diagnostic Category

**State staff also regularly participate in Regional Advisory Committee (RAC) meetings, which focus on issues, related to the implementation of managed care in Texas. The RAC serves as a forum for the identification of issues affecting access, quality and continuity of care. There is a RAC**

**subcommittee that specifically focuses on children with special health care needs. If the RAC proposes a solution for better serving children with special needs, NorthSTAR staff work with the BHO to facilitate the implementation these recommendations to the fullest extent possible.**

**f.**_X__ The State has standards or efforts under way regarding a location's physical Americans with Disabilities Act (ADA) access compliance for enrollees with physical disabilities. Please briefly describe these efforts, and how often compliance is monitored.
**The BHO is contractually required to comply with the ADA and to maintain an office in the service delivery area that meets (ADA) requirements for public buildings. The BHO is also mandated to require all providers and other subcontractors to comply with the ADA. The State monitors ADA compliance by reviewing complaints related to service access.**

**g.**_X_ The State has specific performance measures and performance improvement projects for their populations with special health care needs. Please identify the measures and improvement projects by each population. Please list or attach the standard performance measures and performance improvement projects:
**In addition to actively working on general coordination of care initiatives, NorthSTAR staff, working closely with the STAR (physical health) program, specifically targeted the improvement of coordination of care for the ADHD child population and the chemical dependency (CD) specialty women's population (i.e. women with CD problems who are pregnant or have children). The ADHD care coordination baseline study showed poor communication and coordination of services between the BHO and physical health providers. Evidence of coordination was present in only 20% of the records examined. To address this finding, the Prevention, Education, and Outreach staff at the BHO attended numerous health fairs and distributed educational ADHD "Tip Sheets" to NorthSTAR members. The information was provided both in English and Spanish, and it emphasized the importance of communication with the member's PCP in order to coordinate care. These "Tip Sheets" were also distributed to network providers for them to give this information to NorthSTAR members receiving services at their service location. The BHO continues to provide care coordination information at provider trainings and meetings. The subsequent follow-up study showed a significant increase in the number of records containing evidence of coordination between the BHO and the physical health provider, rising to 68%.**

**In the specialty women's services' population the findings of the baseline study indicated that physical health care was not being routinely**

**accessed, and coordinated with behavioral health services. A baseline review of case notes of pregnant women with substance abuse issues indicated that evidence of coordination was present in 58% of the records. Several interventions were made to improve that finding.**

**The BHO Assistant Medical Director lectured at the STAR Power Conference entitled "Helping You Work with Pregnant Women". The presentation was attended by community workers, health neighborhood organizations, non-profit organizations, church leaders, parish nurses, and others who routinely come in contact with the targeted population.**

- **The BHO Clinical Manager actively participates in the Medicaid Outreach to Expectant Mothers subcommittee. This is a multi-agency group that focuses on coordination of care for pregnant women, including the coordination of physical and behavioral healthcare needs.**

- **The BHO assigned a dedicated Clinical Care Manager to manage the care of all pregnant women who are also in need of behavioral healthcare. This is designed to ensure coordination of care for these members with the three participating managed care organizations.**

- **Physical health care managers are invited to attend the BHO's Clinical Team meetings in order to facilitate optimal coordination of care for pregnant members with substance issues.**

- **The findings of the subsequent follow-up study were encouraging, with evidence of care coordination in 81% of records reviewed.**

## II. State Requirements for MCOs/PIHPs/PAHPs

**Previous Waiver Period**

a._X_ [Required for all elements checked in the previous waiver submittal] Please provide results from all monitoring efforts for each subpopulation noted in the previous waiver, including a summary of any analysis and corrective action taken, to determine the level of compliance with State requirements in the area of special populations for the previous waiver period [items F.II.a-h of the 1999 initial preprint; as applicable in 1995 preprint, item F.II. Upcoming Waiver Period, 1999 Renewal Waiver Preprint].
**The State has used a combination of on-site visits, an external evaluation by the EQRO, consumer satisfaction surveys and detailed complaint analysis to monitor the BHO's compliance with State requirements for**

**serving special populations. The State has also used information gained from focused studies to better understand how well the BHO is able communicate and coordinate with physical health care providers in the STAR program.**

**The State determined that while there have been only a small number of complaints related to care coordination (which were generally resolved to the complainant's satisfaction), the external evaluation and data from the focused studies have indicated that there are multiple areas available for improvement relating to coordination of care. Presently the BHO and the State are working to incorporate these findings into the BHO's Quality Improvement operations.**

**Upcoming Waiver Period** Please check all the items that apply to the State or MCO/PIHP/PAHP.

a._X_ The State has required care coordination/case management services the MCO/PIHP/PAHP shall provide for individuals with special health care needs. Please describe by population.
**The State has included targeted case management for persons with mental illness in the service array for NorthSTAR. This service is available to anyone with serious mental illness requiring the coordination of multiple services.**

b.___ As part of its criteria for contracting with an MCO/PIHP/PAHP, the State assesses the MCO/PIHP/PAHP's skill and experience level in accommodating people with special needs. Please describe by population.

c._X_ The State requires MCOs/PIHPs/PAHPs to either contract or create arrangements with providers who have traditionally served people with special needs, for example, Ryan White providers and agencies which provide care to homeless individuals. If checked, please describe by population.
**The State requires the BHO to contract with Significant Traditional Providers (STPs) of Medicaid mental health services for the first three years of program operations. A number of these STPs comprise the Specialty Provider Networks for the delivery of comprehensive (wrap-around) services to persons with multiple or complex behavioral health care needs. This specialty networks deliver highly specialized services (such as Assertive Community Treatment services) to individuals with chronic or complex behavioral health needs.**

d.___ The State has provisions in contracts with MCOs/PIHPs/PAHPs that allow beneficiaries who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as

PCPs. If not checked, please explain by population.
**NorthSTAR is a behavioral health carve out and as such does not utilize PCPs. Individuals with multiple or complex needs are eligible to receive services through one of the NorthSTAR Specialty Provider Networks (SPNs) which consist of providers experienced in delivering comprehensive wrap around services to individuals with complex behavioral health care needs.**

e.___ The State collects or requires MCOs/PIHPs/PAHPs to collect population-specific data for special populations. Please describe by population.

f._X_ The State requires MCOs/PIHPs/PAHPs that enroll people with special health care needs to provide special services, have unique medical necessity definitions and/or have unique service authorization policies and procedures.

1. Please note any services marked in Appendix D.2.S that are for special needs populations only by population.
**Because NorthSTAR is a behavioral health specialty carve-out, all services are for individuals with special needs. NorthSTAR does utilize Specialty Provider Networks for the delivery of certain intensive wrap-around services for adults with severe mental illness, children with severe emotional disturbance and individuals with multiple or complex needs. Services most commonly delivered through the SPNs include:**
   - **Rehabilitation Treatment Services (behavioral) – including rehabilitative services delivered by an ACT team**
   - **Targeted Case Management for Persons with serious mental illness**
   - **Dual diagnosis services**

2. Please note any unique definitions of “medically necessary services” for special needs populations by population.

3. Please note any unique written policies and procedures for service authorizations for special needs populations by population. For example, are MCOs required to coordinate referrals and authorizations of services with the State’s Title V agency for any special needs children who qualify for Title V assistance?
**The State has mandated that the BHO contract with at least one Specialty Provider Network (SPN) to arrange for or provide intensive treatment and care management for individuals who require multiple services or multiple agency involvement as well as individuals discharged from state psychiatric hospitals when the need for specialty**

**services is indicated.**

**In collaboration with the BHO, the SPN contractor, is required to:**

- **Develop a treatment plan and ensure service coordination for each Enrollee for whom the SPN is responsible;**
- **Assess persons referred by the courts for involuntary mental health commitments and provide service coordination to ensure appropriate coordination of treatment;**
- **Provide specialized mental health services for adults with SMI;**
- **Provide specialty mental health services to children with SED.**

g._X_ The State requires MCOs/PIHPs/PAHPs to identify individuals with complex or serious medical conditions in the following ways:

1._X_ An initial and/or ongoing assessment of those conditions

**Through the intake and assessment process, the BHO is required to identify enrollees eligible for covered services through the SPN and to authorize the Enrollee to receive these services through the SPN.**

2.___ The identification of medical procedures to address and/or monitor the conditions.

3.___ A treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.

4.___ Other (please describe):

h.___ The State specifies requirements of the MCO/PIHPs/PAHPs for the special populations in the waiver that differ from those requirements described in previous sections and earlier in this section of the application. Please describe by population.

**Section G. APPEALS, GRIEVANCES, AND FAIR HEARINGS**

MCOs/PIHPs are required to have an internal grievance procedure approved in writing by the State agency, providing for prompt resolution of issues, and assuring participation of individuals with authority to order corrective action. The procedure allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by 1932(b)(4) of the Act.

Internal grievance procedures are optional for PAHPs.

States, MCOs, PIHPs, and PAHPs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- other requirements for fair hearings found in 42 CFR 431 Subpart E.

**I. Definitions (MCO/PIHP):**

**Upcoming Waiver Period** --

a._X_ [Required]The definition of action in the case of an MCO/PIHP means:

_X_ Denial or limited authorization of a requested service, including the type or level of service;

_X_ The reduction, suspension, or termination of a previously authorized service;

_X__ The denial, in whole or in part, of a payment for a service;

_X__ The failure to provide services in a timely manner

_X__ The failure to act within timeframes required by 42 CFR 438.408(b); or

_X__ For a resident of a rural area with only on MCO, the denial of the enrollee's request to exercise his or her right to obtain services outside the network.

b._X_ Appeal means a request for a review of an action.

c.___ Grievance means an expression of dissatisfaction about any matter other than an action.

**The State does not use the term "grievance" in the BHO contract. The State does use the term "appeal" in the contract however the State has not set forth a specific definition of this term and the term is not used in a way which is contrary to common usage.**

d. Please describe any special processes that the State has for persons with special needs.

**NorthSTAR serves a vulnerable specialty population. During the early design phase of the program, the State determined that it was essential that special protections to be put in place to ensure that consumers were able to receive assistance in advocating for themselves. To that end the State created and supports an independent Local Behavioral Health Authority (LBHA) which has as one of its primary functions the provision of advocacy ombudsman services to consumers and families.**

**Because the LBHA does not provide treatment services and is in no way affiliated with or dependent upon the BHO, it can speak without bias on behalf of consumers. Because it is local, the LBHA is easily accessible to consumers and because it exists solely for the purpose of giving consumers and concerned citizens a voice in how managed care is delivered, it is "consumer friendly".**

**The State has also worked to ensure that consumers have a number of avenues for filing complaints including, but not limited to, filing directly with the BHO, filing through the LBHA, filing directly with the NorthSTAR office, filing though a toll-free managed care complaint line, and filing with the consumer rights office of the Texas Department of Mental Health and Mental Retardation.**

## II. Grievance Systems Requirements (MCO/PIHP):

**Previous Waiver Period**

**a.** [Required for all elements checked in the previous waiver submittal] Please provide results from the State's monitoring efforts, including a summary of any analysis and corrective action taken with respect to appeals, grievances and fair hearings for the previous waiver period [items G.II.a and G.II.b of the 1999 initial preprint; as applicable in 1995 preprint, item G.II 1999 Upcoming Waiver Renewal Preprint]. Also, please provide summary information on the types of appeals, grievances or fair hearings during the previous two-year period following this addendum. Please note how access and quality of care concerns were addressed in the State's Quality Strategy.

**Complaint Reports**

**The State's monitoring of complaints and appeals during the previous waiver cycle did not detect any significant trend or pattern with regard to access, quality of care or other matters related to the provision of services for NorthSTAR enrollees. In fact, the total number of complaints for NorthSTAR has remained quite low. The State believes**

**that the presence of the LBHA in the local area and the active involvement of NorthSTAR staff with regional advocacy and advisory groups has helped to shape a delivery system that is generally responsive to consumers' needs. Chart A.1 on page 13 of this document depicts the total number of complaints from both Medicaid and non-Medicaid consumers, providers, and other sources for the period 11/01 through 4/03. Throughout this period consumer complaints have averaged less than 28 per month.**

**Complaint data indicates that the number of enrollee complaints per-enrollee served for the previous waiver period has been approximately 0.002.**

**It is also significant that no consumers have requested fair hearings during the previous waiver period. The State believes that this is due, at least in part, to an aggressive complaint management process.**

**<u>On-Site Visits</u>**
**NorthSTAR staff use on-site visits as one method of assessing BHO compliance with the NorthSTAR contract. The State has conducted numerous limited on-site visits to evaluate and assess particular aspects of the program including the prior authorization process, hospital utilization, information services functionality and general BHO operations.**

**In April of 2002, the State completed a formal on-site review at ValueOptions, which had as its focus a comprehensive analysis of management functions and processes. This visit resulted in the identification of four specific performance issues:**

- **There was a significant problem with the communications between Value Options corporate office operations and the Dallas office operations.**

- **A systematic program of provider oversight had not been implemented.**

- **Although procedures existed for staff development and training, they were not being adhered to with an effective effort.**

- **The credentialing process at the local level relied entirely on the corporate credentialing program.**

**The BHO submitted a plan of correction and has fulfilled the plan in accordance with the State requested time frames for completion.**

**Access and Quality of Care Concerns**

**The BHO's provider network has stabilized during the second waiver cycle and is currently sufficient to meet the access requirements set forth in the BHO contract.**

**The State's quality improvement strategy has largely focused on assuring adequate coordination of care between physical health and behavioral health managed care programs. The interagency care coordination workgroup meets at least quarterly and includes representatives from the STAR (MCO) program and the BHO, with facilitation provided by the State's quality manager. This group works cooperatively to comply with the guidelines of their 1999 Memorandum of Agreement, which calls for working together to resolve currently identified coordination issues, and to identify and resolve other issues as they arise. An emphasis is placed on developing procedures for effective and timely communication between MCO's and the BHO. The group also strives to develop protocols and processes for coordination of care, including coordination of services for special needs populations and individuals whose symptoms might pose a barrier to standard care coordination.**

**b.** Please mark any of the following that apply:

1._X_ A hotline was maintained which handles any type of inquiry, complaint, or problem.

2._X_ Following this section is a list or chart of the number and types of complaints and/or grievances handled during the waiver period.
**Chart G.1. below provides a summary of consumer complaints by category for the entire program (both Medicaid and indigent) during the period 11/01 through 4/03.**

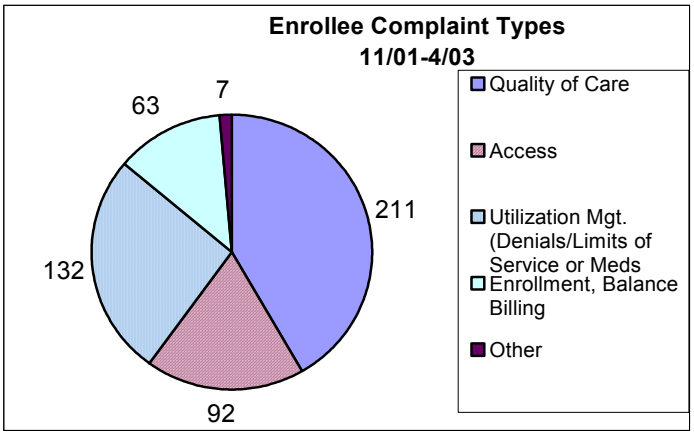


**Chart G.1.**

3.__ There is consumer involvement in the grievance process. Please describe.

**Upcoming Waiver Period** -- Please check requirements in effect for MCO/PIHP grievance processes.

**a. Required Appeals, Grievances, and Fair Hearings Elements for MCOs/PIHPs:**

1._X_ MCO/PIHPs have a system in place for enrollees that include a grievance process, an appeals process, and access to the State's fair hearing process.

2._X_ An MCO/PIHP enrollee can request a State fair hearing under the State's Fair Hearing process. The State permits
(A)_X_ direct access without first exhausting the MCO/PIHP grievance process
(B)__ exhaustion of MCO/PIHP grievance process before a State fair hearing can be accessed

**As in the traditional Texas Medicaid program, enrollees have access to the State's Fair hearing process as afforded under 42 CFR Part 431, Subpart E. At any time, a NorthSTAR enrollee may request a Fair Hearing in writing or verbally through the State's toll-free phone number. The Fair Hearing process is available whenever the BHO takes an action to deny, delay, reduce, suspend, or terminate services, including a denial of a prior authorization request or a determination that covered services are not medically necessary. (An "action" does not include expiration of time-limited services.)**

3._X_ Enrollees are informed about their State fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 CFR 431 Subpart E.

**The Texas Department of Human Services (TDHS) - the Texas Medicaid eligibility agency - provides consumers with information on Fair Hearings at the time of eligibility determination. The NorthSTAR BHO also provides this information in the enrollee through the Enrollee Information Handbook. The BHO is also required to develop, implement and maintain procedures to send written notices to Medicaid**

**Enrollees of the Enrollee's right to request a Fair Hearing from the State whenever the BHO takes an action to deny, delay, reduce, suspend, or terminate services, including a denial of a prior authorization request or a determination that covered services are not medically necessary.**

4._X_ The state specifies a time frame that is no less than 20 days and does not exceed 90 days from the date of action for the enrollee to request an appeal or fair hearing. Specify the time frame does not exceed 90 days.
**The State has mandated that all complaints be resolved within 30 days. All fair hearings (which are conducted by the State, not the BHO) are completed within 90 days of the date on which the request for the fair hearing is filed.**

5._X_ [Optional] The State has time frames for resolution of grievances. Specify the time frame set by the State 30 days
**The State has mandated that all complaints be resolved within 30 days. All fair hearings (which are conducted by the State, not the BHO) are completed within 90 days of the date on which the request for the fair hearing is filed.**

6._X_ The MCO/PIHP issues a written notice of all actions. Notices meet the requirements of 42 CFR 438.404 for language, format, content, and timing.

7._X_ The MCO/PIHP acknowledges receipt of each appeal and grievance when received and explains to the enrollee the process to be followed in resolving his or her issue. If the State has a time frame for MCOs/PHPs to acknowledge complaints and grievances, please specify:
**The State requires that the BHO acknowledge receipt of complaints within 5 days of receipt of complaints for non-emergency services. The Texas Department of Insurance regulations (Article 20A.12 subsection F) requires the complete resolution of complaints related to emergency services within 1 business day.**

8._X_ The MCO/PIHP gives enrollees assistance completing forms or other assistance necessary in filing appeals or grievances (or as appeals and grievances are being resolved).

9._X_ The MCO/PIHP ensures individuals who make decisions were not involved in previous levels of decision making.

10._X_The MCO/PIHP ensures individuals who make decisions are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease.

11._X_The MCO/PIHP ensures the special requirements for appeal, i.e. on oral inquiries, reasonable opportunity to present evidence; ability to examine case file, and inclusion of parties to appeal in 42 CFR 438.406(b) are met.

12._X_Timeframes for resolution:

(a)__ Grievances are resolved within ___ days (may not exceed 90 days from date of receipt by MCO/PIHP)

(b)__ Standard appeals are resolved in ___ days (may not exceed 45 days from date of receipt by MCO/PIHP).

(c)_X_ Expedited appeals are resolved in __ days (may be no more than 3 working days from date of receipt by MCO/PIHP, unless extended).

**The State requires that the BHO acknowledge receipt of complaints within 5 days of receipt of complaints for non-emergency services. The Texas Department of Insurance regulations (Article 20A.12 subsection F) requires the complete resolution of complaints related to emergency services within 1 business day.**

**The State has mandated that all complaints be resolved within 30 days. All fair hearings (which are conducted by the State, not the BHO) are completed within 90 days of the date on which the request for the fair hearing is filed.**

13._X_Timeframes for resolution may be extended for up to 14 calendar days if it meets the requirements of 42 CFR 438.408(c).

14._X_The MCO/PIHP notifies the enrollee in writing of the appeals decision and, if not favorable to the enrollee, the right to request a State fair hearing, including rights to continuation of benefits. The format and content of the notice meet the requirements of 42 CFR 438.408(d)-(e).

15._X_The MCO/PIHP complies with the requirements on availability of and parties to State fair hearings in 42 CFR

438.408(f).

16._X_The MCO/PIHP maintains an expedited review process for appeals when it is determined that the standard resolution timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. This includes the prohibitions on punitive actions, and action following denial of request for expedited resolution in 42 CFR 438.410.
**The State requires that the BHO acknowledge receipt of complaints within 5 days of receipt of complaints for non-emergency services. The Texas Department of Insurance regulations (Article 20A.12 subsection F) requires the complete resolution of complaints related to emergency services within 1 business day.**

17._X_The MCO/PIHP informs the enrollee of any applicable mechanism for resolving the issue external to the MCO's/PIHP's own processes (e.g. independent state review mechanism).

18._X_MCOs/PIHPs maintain a log of all appeals and grievances and their resolution.

19._X_ The State reviews information on each MCO/PIHP's appeals as art of the State quality strategy.

20._X_The State and/or MCO/PIHP have ombuds programs to assist enrollees in the appeals, grievance, and fair hearing process.
**Ombudsperson services are a primary function of the LBHA.**

21.___Other (please specify):

## III. PAHP Requirements

1.__ [Optional] PAHPs have an internal grievance system. Please describe.

2.__ [Required] PAHP enrollees have access to the State fair hearing process.

## Section H. ENROLLEE INFORMATION AND RIGHTS

This section describes the process for informing enrollees and potential enrollees about the waiver program, and protecting their rights once enrolled. Marketing materials (e.g., billboards, direct mail, television and radio advertising) are addressed above in Section A (see A.IV.a).

### I. Information – Understandable; Language; Format

**Previous Waiver Period**

**a.** [Required] Please provide copies of the brochure and informational materials for potential enrollees explaining the program and how to enroll.
**Copies of the Maximus enrollment kits are contained in Attachment #10.**

**Upcoming Waiver Period** -- This section describes how the State ensures information about the waiver program is understandable to enrollees and potential enrollees. Please check all the items that apply to the State or MCO/PIHP/PAHP. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If the State does not check a required item, please explain why.

**a.**_X_ [Required] The State will ensure that materials provided to potential enrollees and enrollees by the State, the enrollment broker, and the MCO/PIHP/PAHP are in a manner and format that may be easily understandable.

**b.**_X_ Potential enrollee and enrollee materials will be translated into the prevalent languages listed below (If the State does not require written materials be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):

1._X_ Spoken by significant number of potential enrollees and enrollees .
2.__ The languages spoken by approximately ___ percent or more of the potential enrollee/enrollee population.
3.__ Other (please explain):

**The State requires all materials to be translated in any language that is used by 10% of covered individuals. Currently all enrollment materials are being translated into English and Spanish. Additional NorthSTAR educational information are also available from the Enrollment Broker in Vietnamese, Cambodian, Hindi, and Gujarati.**

**c.**_X_ [Required] Oral translation services are available to all potential enrollees and enrollees, regardless of languages.

**d.**_X_ [Required] The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program. Please describe.

**The State contracts with an enrollment broker to provide assistance/enroll eligible Medicaid individuals. Each Medicaid eligible is provided an enrollment kit with instructions on how to enroll, and a description of the benefits available to enrollees in the NorthSTAR program. Representatives from the enrollment broker also provide each potential enrollee with a schedule of presentations on STAR and NorthSTAR requirements and benefits at local Department of Human Services field offices and other community based organizations.**

**e._X_** [Required] Each MCO/PIHP will have a mechanism in place to help potential enrollees and enrollees understand the requirements and benefits of the plan. Please describe.

**The State contracts with an enrollment broker to provide assistance/enroll eligible Medicaid individuals. Each Medicaid eligible is provided an enrollment kit with instructions on how to enroll, and a description of the benefits available to enrollees in the NorthSTAR program. Representatives from the enrollment broker also provide each potential enrollee with a schedule of presentations on STAR and NorthSTAR requirements and benefits at local Department of Human Services field offices and other community based organizations.**

**f.**_X_ The State's and MCO/PIHP/PAHP information materials are available in alternative formats that takes into consideration the special needs of those, for example, with visual impairments.

**The State requires the BHO to comply with the Americans with Disabilities Act and to have TDDs in offices where the primary means of offering services is by telephone.**

## II. Potential Enrollee Information

**Upcoming Waiver Period --** This section describes the types of information given to enrollees and potential enrollees. Please check all that apply. Items that are required have "[Required]" in front of them. Checking a required item affirms the State's intent to comply. If a required item is not check, please explain why.

**a._X_[Required] Timing.** The State or its contractor will provide the required information:

(i)_X_at the time the potential enrollee becomes eligible to enrollee

in a voluntary program, or is first required to enrollee in a mandatory program.

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs/PIHPs/PAHPs.

**b. Content** The State and/or its enrollment broker provides the following information to potential enrollees.

1.___ Every new enrollee will be given a brief in-person presentation describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities

2._X_ An initial notification letter
**The Enrollment Broker includes an introductory welcome letter in each enrollment kit mailed to eligible individuals.**

3._X_ A form for enrollment in the waiver program and selection of a plan
**CMS has approved that NorthSTAR may operate with a single BHO.**

4.___ Comparative information about plans

5.___ Information on how to obtain counseling on choice of MCOs/PHPs

6.___ A new Medicaid card which includes the plan's name and telephone number or a sticker noting the plan and/or PCP's name and telephone number to be attached to the original Medicaid card (please specify which method);

7.__ A health risk assessment form to identify conditions requiring immediate attention.

8._X_ [Required] General information about:
(i)_X_Basic features of managed care;
(ii)_X_Which populations are excluded from enrollment, subject to mandatory enrollment; or eligible for voluntary enrollment
(iii)_X_MCO/PIHP/PAHP responsibilities for coordination of care

9._X_ [Required] Specific information about each MCO/PIHP/PAHP (a summary may be provided, but State must provide detailed information upon request):

(i)_X_Benefits covered
(ii)_X_Cost sharing (if any)
(iii)_X_Service area
(iv)_X_ Names, locations, telephone numbers of, and non-English language(s) spoken by contracted providers, and identification of providers not accepting new patients (at a minimum: primary care physicians, specialists, and hospitals)
(v)_X_ Benefits available under state plan but not covered contract, including how and where to obtain; cost sharing; and how transportation provided. For counseling/referral service that MCO/PIHP/PAHP does not provide, State must provide information.

10.__ Other items (please explain):

## III. Enrollee Information

**a.** The State has designated the following as responsible for providing required information to enrollees:
(i)_X_ the State or its contractor
(ii)_X_ the MCO/PIHP/PAHP

**b._X_ [Required] Timing.** The State, its contractor, or the MCO/PIHP/PAHP must provide the information to enrollees as follows:

1._X_For new enrollees, all required information within a reasonable time after the MCO/PIHP/PAHP receives notice of beneficiary's enrollment.

2._X_ For existing enrollees:
(A) State must notify of disenrollment rights at least annually, and if there is a lock-in, by no less than 60 days before the start of each enrollment period.
(B) Notify all enrollees of right to request and obtain required information at least once a year.
(C) Provide written notice of any significant change in required information
(D) MCO/PIHP/PAHP will make a good faith effort to give written notice of termination of contracted provider within 15 days after receipt of termination notice, to each enrollee who received primary care from, or was seen on regular basis by, terminated provider.

**(c)_X_[Required] Content**: The State, its contractor, or the MCO/PIHP/PAHP will provide the following information to all enrollees:

(i)_X_Benefits covered
(ii)_X_Cost sharing
(iii)_X_Individual provider information -- name, location, telephone, non-English languages, not accepting new patients (for MCO, PIHP, PAHP must include at a minimum PCPs, specialists, hospitals)
(iv)_X_Benefits available under state plan but not covered under contract, including conscience clause
(v)_X_Restrictions on freedom of choice within network
(vi)_X_Enrollee rights and protections
(vii)_X_Procedures for obtaining benefits
(viii)_X_Extent to which benefits may be obtained out of network (including family planning)
(ix)_X_Which and how after hours and emergency care are provided including

- _*X*_Definition of emergency medical condition, emergency services, and post-stabilization services
- _X_No prior authorization for emergency services
- _X_Procedure for obtaining emergency services
- _X_Location of emergency settings
- _X_Right to use any hospital for emergency care

(x)__Post-stabilization rules
(xi)__Referral for specialty care
(xii)__[Optional] PAHP grievances procedures if available (if PAHP makes available, need to describe to enrollees)
(xiii)_X_State fair hearing rights

- _X_Right to hearing
- _X_Method for obtaining hearing
- _X_Rules governing representation at hearing

(xiv) _*X*_ MCO/PIHP grievance, appeal, and fair hearing procedures and timeframes, including :

- _X_Right to file grievances and appeals
- _X_Requirements and timeframes for filing grievance or appeal
- _X_Availability of assistance in filing process
- _X_Toll-free number to file grievance or appeal by phone
- _X_Continuation of benefits, including
    - Right to have benefit continued during appeal or fair hearing
    - Enrollee may have to pay for cost of continued services if decision is adverse to enrollee

- _X_Any appeal rights State makes available to provider

(xv)_X_Advance directives
(xvi)__Physician incentive plan information upon request
(xvii)__Information on structure/operation of plan, upon request

## IV. Enrollee Rights:

**Upcoming Waiver Period --** Please check any of the processes and procedures in the following list the State requires to ensure that contracting MCOs/PIHPs/PAHPs protect enrollee rights. The State requires:

**a.**_X_ [Required] MCOs/PIHPs to have written policies with respect to enrollee rights.

**b.**_X_ [Required] Ensures staff and affiliated providers take those rights into account when furnishing services to enrollees

**c.**_X_ [Required] Ensure compliance with any applicable Federal and State laws that pertain to enrollee rights (such as Civil Rights Act, Age Discrimination Act, Rehabilitation Act, and Americans with Disabilities Act)

**d._X_** [Required] The State will assure that each enrollee has the following rights:
(i)_X_ Receive information on their managed care plan
(ii)_X_ Be treated with respect, consideration of dignity and privacy
(iii)_X_ Receive information on treatment options
(iv)_X_ Participate in decisions regarding care, including right to refuse treatment
(v)_X_ Be free from any form of restraint or seclusion used as means of coercion, discipline, convenience, retaliation
(vi)_X_ If privacy rules apply, request and receive copy of medical record and request amendments
(vii)_X_ Be furnished health care services in accordance with access and quality standards.

**e._X_** [Required] The State will assure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO/PIHP/PAHP or its providers treat the enrollee.

**f.__** Other (please describe):

## V. Monitoring Compliance with Enrollee Information and Enrollee Rights

**Previous Waiver Period**

**a.** [Required for all elements checked in the previous waiver submittal] Please include the results from monitoring MCO/PIHP/PAHP enrollee information and rights in the previous two year period, including a summary of any analysis and corrective action taken [items H.IV.a-d of 1999 initial preprint; item A.22 of 1995 preprint, item H.IV. Upcoming Waiver Period, 1999 Waiver Renewal Preprint].

**The State requires the BHO and the Enrollment Broker to submit all enrollee materials for prior approval. The State has reviewed all materials for accuracy and clarity, and to ensure that all required elements are included in the material. (If the State finds that any of the information is misleading, unclear, or does not contain all the required elements, the BHO or Enrollment Broker must make corrections and submit the materials again for approval before using the materials).**

**The State has worked with the BHO and Enrollment Broker to assure that all materials comply with State guidelines.**

**The State also monitors enrollee complaints. The State has not identified any patterns or trends that would indicate that either the BHO or the Enrollment Broker are out of compliance with State requirements related to enrollee information or the protection of rights. No corrective actions related to enrollee information and rights were necessary during the previous waiver cycle.**

**Upcoming Waiver Period** -- Please check any of the processes and procedures the State uses to monitor compliance with its requirements for enrollee information and rights.

**a**._X_ The State tracks disenrollments and reasons for disenrollments or requires MCOs/PIHPs/PAHPs to track disenrollments and reasons for disenrollments and to submit a summary to the State on at least an annual basis.

**b**._X_ The State will approve enrollee information prior to its release by the MCO/PIHP/PAHP.

**c.**_X_ The State will monitor MCO/PIHP/PAHP enrollee materials for compliance in the following manner (please describe):
**The State requires the BHO to submit all enrollee materials for pre-approved prior to distribution to consumers or potential enrollees.**

**d**._X_ The State will monitor the MCO/PIHP/PAHPs compliance with the

enrollee rights provisions in the following manner (please describe):
**The State will continue to monitor all complaints to determine if the BHO is out of compliance with State requirements related to the rights of enrollees. The State will also continue to use satisfaction surveys to determine if consumers feel that their rights are being effectively communicated to them and upheld.**

**Section I. RESOURCE GUIDE**

Below are references that provide information related to Medicaid managed care quality assessment and improvement efforts, and rate setting and risk adjustment methodologies:

Actuarial Research Corporation, Report prepared for the Department of Health and Human Services (DHHS)/the Health Care Financing Administration (HCFA), Capitation Rate Setting in Areas with Eroded Fee-For-Service Base Final Report, 1992.

Actuarial Research Corporation, Setting an Upper Payment Limit Where the Fee for Services Base is Inadequate: Final Report, 1992.

Alpha Center, Report produced for the Robert Wood Johnson Foundation, Risk Adjustment: A Special Report, 1997.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, A Review of Rate Setting Methods of Selected State Medicaid Agencies for Prepaid Health Plans, 1991.

Ann Arbor Actuaries, Inc., Report prepared for DHSS/HCFA, Actuarially Sound Rate Setting Methodologies, 1991.

Conference Report 105-217 to accompany H.R. 2015, the Balanced Budget Act of 1997, (Section 4705 and the regulations being developed to implement these requirements).

Foundation for Accountability (FACCT), Foundation for Accountability (FACCT) Guidebook for Performance Measurement Prototype Summary, 1995.

Independent Assessment Guide Document, Health Care Financing Administration, December, 1998.

Joint Commission for Accreditation of Healthcare Organizations, National Library of Health Care Indicators, 1997.

Massachusetts Medical Society, Quality of Care: Selections from The New England Journal of Medicine, 1997.

Mathematica Policy Research, Inc, The Quality Assurance Reform Initiative (QARI) Demonstration For Medicaid Managed Care: Final Evaluation Report, 1996.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, A Guide for States:

Collecting and Analyzing Medicaid Managed Care Data, 1997.

MEDSTAT Group, Report prepared for U.S. DHHS/HCFA, Survey of Key Performance Indicators, 1997.

Medicaid Management Institute of the American Public Welfare Associations, report prepared for DHHS/HCFA, Medicaid Primary Care Case Management Programs: Guide for Implementation and Quality Improvement, 1993.

Merlis, Mark for National Governor's Association (NGA), Medicaid Contracts with HMOs and Pre Paid Health Plans: A Handbook for State Managers, 1987. (**Rate Setting Description still applicable)

National Academy for State Health Policy, Quality Improvement Primer For Medicaid Managed Care, 1995.

National Academy for State Health Policy, Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care: A Summary, 1995.

National Academy for State Health Policy, Report prepared for HCFA, Quality Improvement System for Managed Care, 1997.

National Committee for Quality Assurance (NCQA), Health Plan Employer Data and Information Set (HEDIS © Current Version ).

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Final report to the President of the United States, Quality First: Better Health Care for All Americans, 1998.

U.S. DHHS/HCFA, A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States, 1993.

U.S. DHHS/PHS/AHCPR, Conquest 1.1: A Computerized Needs-Oriented Quality Measurement Evaluation System, 1996.

U.S. DHHS/PHS/AHCPR, Consumer Assessment of Health Plans (CAHPS) Satisfaction Survey, 1997.

U.S. DHHS/PHS/AHCPR, Putting Research to Work in Quality Improvement and Quality Assurance: Summary Report, 1993, Publication No. 93-0034.

U.S. DHHS/PHS/AHCPR Research Activities Newsletter, Monthly publication.

U.S. DHHS/HCFA and National Committee on Quality Assurance (NCQA), Health Care Quality Improvement Studies in Managed Care Settings: Design and

Assessment: A Guide for State Medicaid Agencies, 1994, Purchase Order #HCFA-92-1279.

U.S. DHHS/HCFA/American Public Welfare Association (APWA), Monitoring Risk-Based Managed Care Plans: A Guide for State Medicaid Agencies.

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Quality Improvement Publications: "Managing Managed Care: Quality Improvement in Behavioral Health."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume One, "An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Two, "An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders."*

U.S. DHHS/PHS/SAMHSA, Managed Care Initiative Technical Assistance Publications: Volume Seven, "Technical Assistance Publication Series (TAP) 22: Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers."*

Websites: www.hcfa.gov, www.ahcpr.gov or outside organizations such as www.ncqa.org, www.nashp.org, www.samhsa.gov, www.apwa.org.

*document can be ordered through the National Clearinghouse on Alcohol and Drug Information (NCADI) 800/729-6686 or found on the SAMHSA Web Site at www.samhsa.gov/mc/TAS.htm.